HEALTH CARE COST CONTAINMENT: ARE AMERICA'S AGED PROTECTED?

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

JULY 9, 1985

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HEALTH CARE COST CONTAINMENT: ARE AMERICA'S AGED PROTECTED?

TUESDAY, JULY 9, 1985

House of Representatives,
Select Committee on Aging,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., room 345, the Capitol, Hon. Edward R. Roybal (chairman of the committee) presiding.

Members present: Representatives Roybal, Pepper, Hughes, Lloyd, Oakar, Mica, Synar, Skelton, Erdreich, Sisisky, Gordon, Manton, Stallings, Regula, Wortley, Schneider, Ridge, McCain, Gekas, Boehlert, Bentley, Lightfoot, Fawell, Meyers, Henry, Kolbe, and Schuette.

Staff present: Fernando Torres-Gil, staff director, Nancy Smith, professional staff member, Gary Christopherson, professional staff member; Austin Hogan, communications director, Judith Lee, executive assistant, Christinia Mendosa, professional staff member, Carolyn, Griffith, staff assistant, Diana Jones, staff assistant, Paul Schlegel, minority staff director, and Anne Riser, minority executive secretary.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The Chairman. The committee will come to order.

Ladies and gentlemen, the purpose of this hearing is to determine whether cost containment measures under Medicare and Medicaid, combined with budget costs to social services, are limiting the elderly's access to long-term care and community services.

This is the committee's second hearing on the impact of cost containment on America's aged. In February we heard testimony from providers and consumers that hospital DRG's are negatively affecting the quality of health care. That testimony convinced me to introduce my Quality Assurance Bill, H.R. 1970, which will substantially upgrade the current quality assurance system.

Today, we will look at the collective impact of cost control measures on the elderly's access to needed nursing home, home health, and community services. At a time when pressure on hospitals to discharge patients earlier is increasing the need for long-term care—we find that there is mounting evidence to suggest that more restrictive administration policies are limiting the elderly's access to this care.

The evidence begins with the administration's repeated assault on the Health and Human Services budget over the past 5 years.

Added to this are new regulations under Medicare and Medicaid that discourage providers and States from participating in the few public programs that cover long-term care. The latest regulations came this past Friday when HCFA, the agency in charge, decided to limit costs for home health care. And that added, of course, to the pressure on providers. Other evidence will be presented by witnesses today based on studies conducted at my request. How these measures would affect people is the subject of this hearing.

The squeeze on providers, States and local governments is hurting the elderly and their families. The fact that Governor Graham and Mayor Schaefer, others, along with consumers and providers are here testifies to the fact that there is a problem. They are concerned over this great issue. And I greatly appreciate their presence and look forward to their testimony.

I would like to submit some correspondence between our committee and the Department of Health and Human Services at this time. Hearing no objections, so ordered.

[The correspondence submitted by Chairman Roybal follows:]

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC, June 24, 1985.

Hon. MARGARET M. HECKLER,
Secretary, Department of Health and Human Services,
Washington, DC.

DEAR SECRETARY HECKLER: On July 9, 1985, the House Select Committee on Aging will hold a hearing on the impact of health care cost containment measures on the elderly's access to long term care and community services. In lieu of formal testimony from the Department, I am requesting that answers to the House and Senate Aging Committees' earlier questions on waiver of liability (enclosed) and to additional questions on cost containment (also enclosed) be provided to the Committee by July 3, 1985.

The purpose of the July 9th hearing is to determine whether and to what extent cost containmnet measures under Medicare, Medicaid and human service programs are limiting beneficiary access to long term care and community serivces. The Committee's concern is that at a time when hospital prospective reimbursement is increasing the elderly's need for nursing home, home health, and community services, budgetary and regulatory contraints may, collectively, be limiting the edlerly's access to these types of care.

I understand the Department's desire to administer programs under its purview in an appropriate and cost-effective manner. I also know that in the interest of cost containment, the pendulum can swing so far in the direction of savings that beneficiaries lose access to essential services for which they are rightfully entitled. This critical question of beneficiary access will be addressed in testimony from providers, local and state governments and consumers at the July hearing.

Thank you for your cooperation. The Department's answers should be forwarded to the Committee in Room 712, House Office Building Annex I, by close of business Friday, July 5, 1985. Questions regarding my request should be directed to Ms. Nancy Smith of the Committee staff at (203) 226-3375.

Sincerely,

EDWARD R. ROYBAL,
Chairman.

ADDITIONAL QUESTIONS OF SECRETARY MARGARET HECKLER ON IMPACT OF COST CONTAINMENT MEASURES FOR JULY 9, 1985, HEARING

1. Given the incentive for shorter lengths of stay under hospital DRG's and, hence, the growing demand for in-home and community long term care alternatives, how will the Department ensure that recent cost containment measures under Medicare (e.g., changes to wavier of liability, freeze on provider reimbursement levels, and increased pressure on fiscal intermediaries) and limitations on the Medicaid

2176 Home and Community Based Waiver Program will not result in decreased provider and state participation?

2. What, if any, preliminary data are available on changing patterns of provider and state participation in Medicare and in the Medicaid 2176 Waiver Program over the past 24 months? At a minimum, please indicate the number of nurisng home and home health providers who have entered, withdrawn or changed their level of participation in the Medicare program during this period. Please also list the states that have applied for 2176 waivers during each of the past two years; the number of waivers that have been approved, rejected and withdrawn; and which states are in jeopardy of losing their 2176 Waiver as a result of the Department's new requirements for Federal Financial Participation (published in March 13, 1985 Federal Register).

3. What steps is the Department taking to measure the collective impact of these cost containment measures under Medicare, Medicaid, Older American's Act programs and Social Service and Community Service Block Grants on the elderly's access to long term care community services?

4. What data are currently available on changing utilizaiton patterns of Medicare, Madicaid, Older American's Act and Social Service and Community Service Block grants long term care and community services? At a minimum, please estimate the number of elderly benificiaries under the nursing home, home health and community service components of these programs for each of the years 1978, 1985.

5. The Department, in its report to Congress on Medicare's skilled nursing facility benefit, predicted that "Medicare's hospital prospective payment system may increase the use of Medicare SNF services because it gives hospitals a strong financial incentive to discharge patients as soon as is medically appropriate." Despite this increasing demand for nursing home and, by extrapolation, home health services, a recent survey undertaken for the Committee of Medicare providers indicates that denial rates are increasing.

Does the Department have data suggesting otherwise? How do you reconcile increasing numbers of long term care claimants and heavier care needs with increasing denial rates?

Please also provide estimates of denial and reversal rates for Medicare and Medicaid claims for long term care services between 1978 and 1985.

6. Element 16 of Sub-Section 2901.1 (Contractor Performance Evaluation Program) of the Health Insurance Manual (13-2) sets standards for the cost-effective administration of a Medical Review/Utilization Review (MR/UR) program based on the ratio of dollars recovered to contract dollars apportioned to the intermediary for MR/UR functions. It is my understanding that the failure of an intermediary to stay above the minimum "Passing" ratio of $5.00/$1.00 is grounds for failing the entire 2901 section evaluation and contract termination.

Please explain how these ratio's were derived. Are they based on historical data on the rate and dollar value of claim denials for home health, nursing home, hospital and other services covered by Medicare? On what basis are adjustments to the ratios and the weighting of Element 16 mode?

Please also explain how the weighting of this element had changed over the past four quarters and how, accordingly, this impacts intermediary incentives for increased denials.

Please answer these same two questions for the similar standards used in evaluating intermediary performance of cost audit functions (Section 2901.6, Element 16).

7. It is also my understanding that data on claim reversals are not factored into intermediary performance evaluations under the Contractor Performance Evaluation Program (CPEP).

Is this true? If so, what is to prevent an intermediary from increasing initial denial, rates in order to meet CPEP standards, knowing that claims may be subsequently reversed without any effect on their performance rating?

How are reversal rates monitored by the Department? Please indicate the number and percentage of denied nursing home and home health claims under Medicare for each of the past four quarters; the average time between claim denial and reversal; and the estimated administrative costs resulting from denials reversed after reconsideration; the estimated costs to clients and providers attributable to successful claims appeals.

8. As a member of the House Appropriations Committee, I asked the Department several questions this year related to newly issued regulations under the Medicaid 2176 Home and Community Based Waiver Program. In response, the Department indicated that several states had expressed dissatisfaction with the new reporting requirements and that Department staff had been directed to investigate "alterna-

tives." Please specify the status of this review, what alternatives are being considered and how states are being involved?

9. The Department's revised regulations for the Medicaid 2176 Program have been criticized on the grounds that the cost formula rewards states with empty nursing home beds and penalizes those with high occupancy rates and moritoriums nursing home bed expansion. What is the Department's position on this and is this among the provisions being reconsidered?

Questions on Waiver of Liability Submitted to Secretary Heckler by House and Senate Aging Committees, April 1985

IMPACT ON BENEFICIARIES, PROVIDERS AND PROGRAM COSTS

1. What is the estimated number of beneficiaries who would be denied access to hospital, nursing home and home health services if, in response to the waiver of liability ruling being imposed, providers choose to withdraw from the Medicare program or tighten their criteria for accepting potential Medicare patients?

2. During 1984 and 1985, what was the total number of Medicare claims submitted for hospital, nursing home and home health reimbursement? What number of these were denied and of those denied, what number were appealed? What was the denial rate and rate of reversal in each year? What was the dollar value of post-hospital Medicare benefits denied after final appeal during each year?

COSTS AND COST SAVINGS

1. What is the potential increase in costs to the beneficiary and to Medicaid under the proposed ruling as, with decreasing access to Medicare services, more patients enter nursing home as private pay patients and subsequently spend down to Medicaid?

2. What is the estimated additional cost that would be incurred by Medicare providers annually as a result of denied claims if the proposed waiver of liability ruling were imposed?

3. Has the Department estimated the cost savings under the proposed ruling that includes the costs associated with case reviews, reconsiderations and appeals? What proportion of the estimated savings would result from providers withdrawing from the Medicare program?

PROCEDURES AND INCENTIVES FOR INTERMEDIARIES AND PROVIDERS

1. What standards and criteria for claims review are in place of being developed to provide guidance to providers and intermediaries to ensure that beneficiary claims are fairly and consistantly reviewed within and among states?

2. If the proposed rule is imposed, how would HCFA assure that an increase in the rate of denial for legitimate claims would not result, assuming that providers will tend to deny cases in which there is any doubt of coverage? What protections would be built in to protect the beneficiary in such cases?

3. What, if any, incentives exist to discourage high reversal rates in client appeals that might be associated with particular intermediaries? Is a provider's reversal rate considered in determining whether a pattern of inappropriate utilization exists?

COMMENT PERIOD

Please explain the necessity of imposing a 30-day comment period for a rule that has taken over two years to develop. This shortened time period imposes difficulties on individuals and organizations wanting to become fully informed and to fully assess the impact of proposed rulings.

U.S. Senate,
Special Committee on Aging,
Washington, DC.

Hon. Mararet M. Heckler,
Secretary, Department of Health and Human Services,
Washington, DC.

Dear Madam Secretary: On February 12, 1985, the Department of Health and Human Services published in the Federal Register proposed rules on the Medicare Waiver of Liability. Members of the Senate Special Committee on Aging and the

House Select Committee on Aging have serious reservations about the impact of proposed regulatory changes on elderly Medicare beneficiaries.

As you are aware, the House Select Committee on Aging held a hearing in February on the impact of cost containment proposals on elderly beneficiaries. In addition, the Senate Special Committee on Aging received a preliminary report prepared by the General Accounting Office on the impact of hospital DRG on post-hospital long term care services. Testimony from the hearing and preliminary results of the GAO study demonstrate that with increasing pressure on hospitals to discharge patients "quicker and sicker," more and more patients are seeking post-hospital nursing home and home health services. Given the increasing need for post-hospital care, we are deeply concerned that the Department's proposed regulatory changes will ultimately decrease the access of Medicare patients to the services they need, and also increase the number of coverage denials.

We commend the Department on havig convened an internal task force to reconsider the proposed rule in light of concerns raised during the comment period. We fully agree that a range of issues must be addressed before the Department proceeds any further with implementation. Appended to this letter are questions which should be taken up by the task force and for which we request your written response by May 15, 1985. In addition, we would like to know the Department's timetable and plans for the task force and for implementing final regulations.

We look forward to your response and to working with you to resolve this important issue.

Sincerely,

JOHN HEINZ,
Chairman, Special Committee on Aging, U.S. Senate.
JOHN GLENN,
Ranking Minority Member, Special Committee on Aging, U.S. Senate.
EDWARD R. ROYBAL,
Chairman, Select Committee on Aging, U.S. House of Representatives.
MATTHEW J. RINALDO,
Ranking Minority Member, Select Committee on Aging, U.S. House of Representatives.

IMPACT ON BENEFICIARIES, PROVIDERS AND PROGRAM COSTS

1. What is the estimated number of beneficiaries who would be denied access to hospital, nursing home and home health services if, in response to the waiver of liability ruling being imposed, providers choose to withdraw from the Medicare program or tighten their criteria for accepting potential Medicare patients?
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2. What is the estimated additional cost that would be incurred by Medicare providers annually as a result of denied claims if the proposed waiver of liability ruling were imposed?
3. Has the Department estimated the cost savings under the proposed ruling that includes the costs associated with case reviews, reconsiderations and appeals? What proportion of the estimated savings would result from providers withdrawing from the Medicare program?

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1. What standards and criteria for claims review are in place or being developed to provide guidance to providers and intermediaries to ensure that beneficiary claims are fairly and consistently reviewed within and among states?

2. If the proposed rule is imposed, how would HCFA assure that an increase in the rate of denial for legitimate claims would not result, assuming that providers will tend to deny cases in which there is any doubt of coverage? What protections would be built in to protect the beneficiary in such cases?

3. What, if any, incentives exist to discourage high reversal rates in client appeals that might be associated with particular intermediaries? Is a provider's reversal rate considered in deterining whether a pattern of inappropriate utilization exists?

COMMENT PERIOD

Please explain the necessity of imposing a 30-day comment period for a rule that has taken over two years to develop. This shortened time period imposes difficulties on individuals and organizations wanting to become fully informed and to fully assess the impact of proposed rulings.

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, June 20, 1985.

Hon. EDWARD R. ROYBAL,
House of Representatives, Washington, DC.

DEAR MR. ROYBAL: We have received your letter commenting on various aspects of the proposed regulations to change the administration of the Medicare waiver of liability for providers and beneficiaries. We understand your concerns and will be considering them as we develop the final regulation.

As you know the original recommendation upon which this proposal was based was contained in a General Accounting Office report dated March 1983 (GAO-HRD-83-38). The basis for the GAO report and our subsequent proposal was, of course, a conviction that the Medicare program should not pay for care that is not medically reasonable and necessary and, therefore, not covered under the provisions of the Medicare statute. As indicated in the preamble to the Notice of Proposed Rulemaking, we estimated substantial savings would result from our proposed changes, eliminating payments now made for a certain percentage of noncovered cases under criteria and thresholds which hold providers harmless for certain erroneous decisions.

The objective of the proposed regulations was not, of course, to eliminate the provision that permits HCFA to waive a provider's liability under appropriate circumstances as is authorized by Section 1879 of the Social Security Act. Instead, the proposal was to eliminate a presumption that a provider should not be held liable for erroneous decisions, rather than permitting waiver on the basis of a case by case review. As indicated in the preamble accompanying the proposed regulation, we considered the impact of the proposal on both providers and beneficiaries.

We are pleased to receive your comments about the formation of an internal task force within the Health Care Financing Administration to consider issues raised during the comment period. That group has already begun reviewing the voluminous correspondence which we have received on this subject. Many of these concerns are similar to those raised in the attachment to your letter. We are asking the Task Force to do a careful and thorough job of reviewing and analyzing these comments as well as collecting additional data where this seems desirable. These endeavors are estimated to take the better part of the next two months. Since your questions are so closely interrelated to others that we will be considering during this period, we have been unable to respond to your specific inquiries by May 15, as you requested.

We will provide you with an additional response addressing your specific inquiries by early July which will be well before we are prepared to proceed with a final regulation.

I hope that you will find this information helpful.

Sincerely,

MARGARET M. HECKLER,
Secretary.

Department of Health & Human Services,
Office of the Secretary,
Washington, DC, July 3, 1985.

Hon. Edward Roybal,
Chairman, Select Committee on Aging,
House of Representatives, Washington, DC.

Dear Mr. Chairman: This is in response to your letter requesting that answers to certain waiver of liability and cost containment questions be provided to the Committee prior to its July 9 hearing on the impact of cost containment on the elderly's access to long term care and community services.

As noted in our June 20 letter, based on the review and analysis of an internal Health Care Financing Administration (HCFA) task force, responses to your specific inquiries about the waiver of liability regulations will be forthcoming; however, they will not be available prior to your July 9 hearing.

Per conversations with the Committee staff several of the cost containment questions also cannot be answered at this time either due to the lack of data or because of those clearance constraints. However, we have enclosed the answers to those questions for which data is readily available and we will submit the other answers for the record at a later date.

If we can be of further assistance, please let me know.

Sincerely yours,

Lawrence J. DeNardis,
Acting Assistant Secretary for Legislation.

Enclosure.

Question. Given the incentive for shorter lengths of stay under hospital DRGs and, hence, the growing demand for in-home and community long-term care alternatives, how will the Department ensure that recent cost containment measures under Medicare (e.g., changes to waiver of liability, freeze on provider reimbursement level, and increased pressure on fiscal intermediaries) and limitations on the Medicaid 2176 Home and Community Based Waiver Program will not result in decreased provider and State participation?

Answer. HCFA does not believe that the publication of the final regulations on home and community-based services waivers on March 13, 1985, will result in any decreased State participation in the home and community-based services waivers. Since publication of the regulations on March 13, HCFA has received 9 requests for new home and community-based service waivers and 8 requests for renewal of home and community-based service waivers. In addition, on May 1 HCFA sent a letter to all States advising them of the additional assurances and information required for all approved waiver programs. Since that date, HCFA has received information and assurances on 54 existing approved waivers in response to the March 13 regulations and May 1 letter. This immediate and overwhelming response clearly indicates that the new regulations have not caused a decline in State interest in participating in home and community-based service waivers. Further, the Health Financing Administration is committed to working with States to develop approvable home and community-based service waivers.

Question. What, if any, preliminary data are available on changing patterns of provider and State participation in Medicare and in the Medicaid 2176 Waiver Program over the past 24 months? At a minimum, please indicate the number of nursing home and home health providers who have entered, withdrawn or changed their level of participation in the Medicare program during this period. Please also list the States that have applied for 2176 waivers during each of the past 2 years; the number of waivers that have been approved, rejected and withdrawn; and which States are in jeopardy of losing their 2176 Waiver as a result of the Department's new requirements for Federal Financial Participation (published in the March 13, 1985 Federal Register).

Answer. Over the last 24 months there has been no decline in the number of waiver requests received; in fact, there has been approximately a 25 percent increase in the number of waivers received. During the period July 1, 1983 through June 30, 1984, a total of 39 waiver requests were received—37 for new waiver programs and 2 for extension of existing programs. During the period July 1, 1984 through June 26, 1985, a total of 50 requests were received—30 for new waiver programs and 20 for extension of existing programs.

During the period, July 1, 1983 through June 30, 1984, 31 waivers were approved; 2 were disapproved and 2 withdrawn. During the period July 1, 1984 through June 26, 1985, 30 waivers were approved, 10 withdrawn, and 16 disapproved. Following is a listing of all waivers received over the last 24 months:

2176 WAIVERS RECEIVED

State	Received	Action
July 1, 1983 to June 30, 1984:		
Alabama (0068)	Aug. 31, 1983	Approved Dec. 4, 1984.
Colorado model (40112)	Mar. 26, 1984	Additional information requested.
Connecticut model (40110)	Dec. 28, 1983	Approved Mar. 8, 1984.
Florida (0074)	June 12, 1984	Approved Jan. 23, 1985.
Florida (0075)	Apr. 2, 1984	Disapproved Nov. 21, 1984.
Florida model (40113)	July 28, 1983	Additional information requested.
Florida model (40114)	do	Do.
Georgia model (40103)	Aug. 31, 1983	Approved Sept. 23, 1983.
Georgia renewal (0112)	Apr. 16, 1984	Approved Nov. 1, 1984.
Idaho (0076)	Apr. 3, 1984	Approved Nov. 21, 1984.
Illinois model (40117)	Dec. 29, 1983	Disapproved Aug. 23, 1984.
Indiana (0066)	July 5, 1983	Approved Aug. 28, 1984.
Iowa (0078)	Jan. 23, 1984	Disapproved Jan. 11, 1985.
Iowa (0079)	do	Do.
Iowa (0080)	do	Do.
Iowa model (40111)	do	Approved Mar. 17, 1984.
Maryland model (40118)	Sept. 13, 1983	Approved Jan. 31, 1985.
Massachusetts (0059)	Dec. 12, 1983	Approved Mar. 9, 1984.
Massachusetts (0064)	July 13, 1984	Approved May 21, 1984.
Michigan model (40119)	June 11, 1984	Approved Jan. 25, 1984.
Minnesota (0061)	Jan. 19, 1984	Approved Apr. 17, 1984.
Missouri (0065)	Nov. 10, 1983	Approved May 21, 1984.
Nebraska (0063)	July 5, 1983	Approved Apr. 17, 1984.
Nebraska (0092)	do	Disapproved Apr. 24, 1984.
New Hampshire (0060)	Dec. 29, 1983	Approved Mar. 22, 1984.
New Mexico (0056)	July 18, 1983	Approved Dec. 22, 1983.
New Jersey model (40104)	July 15, 1983	Approved Oct. 4, 1983.
North Dakota (0054)	July 8, 1983	Approved Dec. 7, 1983.
Ohio (0067)	Sept. 1, 1983	Approved Aug. 30, 1984.
Ohio model (40106)	Aug. 22, 1983	Approved Sept. 21, 1983.
Ohio model (40108)	Nov. 7, 1983	Approved Dec. 8, 1983.
Ohio model (40109)	Oct. 24, 1983	Approved Dec. 29, 1983.
Oklahoma (0094)	Dec. 5, 1983	Approved Nov. 26, 1984.
Oklahoma (0095)	Dec. 5, 1983	Additional information received.
Oregor renewal (0113)	June 4, 1984	Approved Jan. 31, 1985.
South Carolina (0104)	Apr. 26, 1984	Approved Dec. 3, 1984.
Texas (0110)	May 25, 1984	Approved Apr. 12, 1985.
Texas model (40122)	June 18, 1984	Approved Mar. 5, 1985.
Wisconsin (0111)	May 14, 1984	Additional information received.
July 1, 1984 to June 26, 1985:		
Alaska (0119)	Jan. 15, 1985	Additional information requested.
California renewal (0002.90)	Mar. 27, 1985	Withdrawn June 20, 1985.
California	May 28, 1985	Pending.
Colorado renewal (0006.90)	Mar. 13, 1985	Approved May 30, 1985.
Colorado	June 3, 1985	Pending.
Colorado renewal	do	Do.
Florida renewal (0010.90)	Dec. 6, 1984	Approved Mar. 6, 1985.
Florida renewal (0010.91)	Mar. 18, 1985	Approved June 14, 1985.
Florida (0116)	Oct. 18, 1984	Approved June 5, 1985.
Florida (0118)	Dec. 26, 1984	Pending.
Georgia model (40115)	Aug. 6, 1984	Approved Dec. 11, 1984.
Georgia model (40116)	do	Approved Dec. 7, 1984.
Illinois model (40127)	Jan. 7, 1985	Additional information requested.
Kansas renewal (0018.90)	Dec. 13, 1984	Approved Mar. 14, 1985.
Louisiana renewal (0114)	Oct. 9, 1984	Disapproved Jan. 7, 1985.
Louisiana renewal (0115)	do	Do.
Louisiana renewal (0121)	Apr. 1, 1985	Additional information requested.
Louisiana model (40129)	Mar. 19, 1985	Withdrawn May 16, 1985.
Maine (0088)	Aug. 27, 1984	Approved Nov. 26, 1984.
Maine	June 3, 1985	Pending.
Minnesota renewal (0025.90)	Apr. 24, 1985	Withdrawn June 19, 1985.

2176 WAIVERS RECEIVED—Continued

State	Received	Action
Minnesota model (40128)	Feb. 13, 1985	Approved May 13, 1985.
Minnesota model (40130)	Mar. 25, 1985	Additional information requested.
Missouri renewal (0026.90)	Feb. 6, 1985	Approved May 7, 1985.
Mississippi	May 23, 1985	Withdrawn June 10, 1985.
Nevada renewal (0030.90)	Mar. 29, 1985	Withdrawn May 17, 1985.
Nevada	June 3, 1985	Pending.
New Jersey model (40123)	Oct. 15, 1984	Approved May 7, 1985.
New Mexico model (40120)	Aug. 31, 1984	Approved Mar. 7, 1985.
New Mexico model (40124)	Dec. 28, 1984	Additional information requested.
New York model (40125)	Dec. 31, 1984	Additional information requested.
North Carolina renewal (0035.90)	Apr. 2, 1985	Pending.
Ohio model (40121)	July 11, 1984	Additional information requested.
Oregon renewal (0117)	Nov. 9, 1984	Approved May 30, 1985.
Pennsylvania (0096)	Aug. 16, 1984	Pending.
Pennsylvania (0099)	Aug. 27, 1984	Additional information requested.
Pennsylvania (0100)	July 5, 1984	Do.
Rhode Island renewal (0040.90)	Oct. 9, 1984	Approved Jan. 7, 1985.
Rhode Island model (40126)	Jan. 7, 1985	Additional information requested.
South Dakota renewal (0044.90)	Feb. 12, 1985	Approved May 13, 1985.
Tennessee (0105)	Sept. 17, 1984	Disapproved Dec. 14, 1984.
Tennessee	June 25, 1985	Pending.
Tennessee model	May 31, 1985	Do.
Texas (0109)	July 24, 1984	Disapproved Apr. 9, 1985.
Vermont renewal (0047.90)	Dec. 31, 1984	Approved Mar. 14, 1985
Vermont renewal (0047.91)	Mar. 28, 1985	Approved June 11, 1985.
Virginia renewal (0048.90)	Feb. 19, 1985	Approved May 13, 1985.
Virginia (0120)	Feb. 11, 1985	Disapproved May 10, 1985.
Virginia (0122)	Apr. 9, 1985	Additional information requested.
West Virginia renewal (0051.90)	Mar. 13, 1985	Disapproved June 10, 1985.

The following table shows trends in participating Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF), and Home Agencies (HHA).

Since June 1, 1983 these activities have occurred:

SNFs terminated:	
Medicare	141
Medicaid	406
New SNFs	2,277
Changes in SNF level of care:	
SNF to ICF	111
ICF to Medicaid SNF	104
ICF to Medicare SNF	325
HHAs terminated	371
New HHAs	1,967

Question. The following tables show trends in utilization of Medicare and Medicaid participating nursing home and home health agencies by aged persons:

MEDICARE SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES: AGED PERSONS SERVED AND UNITS OF SERVICE PER PERSON SERVED, 1978-83

	Skilled nursing facilities		Home health agencies persons served
	Persons served	Covered days per person served	
Calendar year:			
1984 (estimate)	NA	NA	1,300,000
1983	257,000	34	1,230,000
1982	244,000	34	1,100,000
1981	243,000	34	1,000,000
1980	248,000	34	890,000

MEDICARE SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES: AGED PERSONS SERVED AND UNITS OF SERVICE PER PERSON SERVED, 1978-83—Continued

	Skilled nursing facilities		Home health agencies persons served
	Persons served	Covered days per person served	
1979	247,000	33	810,000
1978	267,000	33	720,000

Source: HCFA BDMS published and unpublished data from the "Annual Medicare Program Statistics" series, the Current Utilization series and special purposes user files

MEDICARE AND MEDICAID: NUMBER OF LONG-TERM FACILITIES BY TYPE, AS OF JAN. 1, 1978-85

	Skilled nursing facilities		Intermediate care facilities		
	Title 18 only and 18-19	Title 19 only	Mentally retarded	All others	Home health agencies
Year:					
1985	6,183	2,422	2,577	11,582	5,237
1984	5,760	2,493	2,066	11,450	4,235
1983	5,510	2,570	1,445	11,304	3,627
1982	5,295	2,555	1,453	11,157	3,169
1981	5,155	NA	NA	NA	3,012
1980	5,055	NA	NA	NA	2,858
1979	4,982	NA	NA	NA	2,715
1978	4,461	NA	NA	NA	2,496

Source: HCFA, BDMS published and unpublished date from HCFA's provider of service file

MEDICAID NURSING HOME AND HOME HEALTH AGENCIES: AGED RECIPIENTS, 1978-84

	Skilled nursing facilities	Intermediate care facilities	Home health agencies
Fiscal year:			
1984	483,000	697	128
1983	495,000	691	NA
1982	461,000	644	105
1981	501,000	633	102
1980	480,000	615	108
1979	483,000	597	NA
1978	518,000	575	106

Source: HCFA, Office of the Actary, unpublished data.

Question. The Department, in its report to Congress on Medicare's skilled nursing facility benefit, predicted that "Medicare's hospital prospective payment system may increase the use of Medicare SNF services because it gives hospitals a strong financial incentive to discharge patients as soon as is medically appropriate." Despite this increasing demand for nursing home and, by extrapolation, home health services, a recent survey undertaken for the Committee on Medicare providers indicates that denial rates are increasing.

Does the Department have data suggesting otherwise? How do you reconcile increasing numbers of long term claimants and heavier care needs with increasing denial rates? How do you reconcile increasing numbers of long term care claimants and heavier care needs with increasing denial rates?

Answer. Current available data indicate Medicare denial rates are only sightly increasing for and HHA services. Denial rates (measured in terms of denial notices expressed as a percentage of claims processed) for the first year of recorded experience (FY 1979) through the most recent period for which data are available (first 6 months of FY 1985) are shown for HHAs below:

Fiscal year:	HHA
1979	1.9
1980	2.2
1981	2.2
1982	1.5
1983	1.2
1984	1.6
1985 [1]	2.0

[1] 1st 6 mo only.

No denial data are available for Medicaid SNF and HHA services. Medicare SNF denial data will be available at a later date.

Although there has been a slight increase in the rate of claims denials, the Medicare program has been supporting heavier care needs as evidenced by the increasing amounts paid out for SNF and HHA services. Data from the 1985 Annual Report of the Board Trustees of the Federal Hospital Insurance Trust Fund reflects these increases and are shown below:

MEDICARE BENEFIT PAYMENTS

[In millions of dollars]

	SNF	HHA
Fiscal year:		
1983	495	1,669
1984	544	1,995
1985 [1]	601	2,290
1986 [1]	655	2,612

[1] Projected.

Question. Element 16 of Sub-Section 2901.1 (Contractor Performance Evaluation Program) of the Health Insurance Manual (13-2) sets standards for the cost-effective administration of a Medical Review/Utilization Review (MR/UR) program based on the ratio of dollars recovered to contract dollars apportioned to the intermediary for MR/UR functions. It is my understanding that the failing of an intermediary to stay above the minimum "passing" ratio of $5.00/$1.00 is grounds for failing the entire 2901 section evaluation and contract termination.

Please explain how these ratio's were derived. Are they based on historical data on the rate and dollar value of claim denials for home health, nursing home, hospital and other services covered by Medicare? On what basis are adjustments to the ratios and the weighting of Element 16 made?

Please also expalain how the weighting of this element has changed over the past four quarters and how, accordingly, this impacts intermediary incentives for increased denials.

Please answer these same two questions for the similar standards used in evaluating intermediary performance of cost audit functions (Sectioon 2901.6, Elemnent 16.)

Answers. The Cost/benefit of 5:1 for medical review by intermediaries is based on historical data. Both medical review and audit are critical elements. Failure to succeed in these elements could lead to various contract actions including termination. Adjustments are made to the CPEP ratios based on an analysis of contractor data and current law.

The acceptable ratio for medical review/utilization review was reduced in FY 84 from 5:1 to 3:1 for intermediaries. For FY 85, the ratio has been raised to 5:1 based on a further analysis of data. In order for contractors to achieve the MR/UR and audit elements, HCFA is providing more guidelines to the intermediaries on the areas to review.

The audit ratio of $5.00/$1.00 is based on historical data and various factors which constitute provider reimbursement under the TEFRA cost limits. In FY 85, our intermediareies are auditing provider cost reports from the period October 1, 1982 until September 30, 1983. These cost reports are governed by the TEFRA cost limtis before the implementation of prospective payment.

The cost/benefit ratio is traditionally the highest for hospitals. These ratios have ranged as high as 14:1 for PPS base period audits. However, because of the target calculations and incentive payments to hospitals, the audit ratio for TEFRA cost limits is projected to be cut in half. When this is coupled with the lower ratios achieved from auditing providers other than hospitals an overall figure of 5:1 is derived.

The 5:1 ratio is constantly being evaluated to determine its applicability to the current audit environment. As indicated in the question below on CPEP we believe that intermediaries do not have an incentive to increase denials to pass the audit or medical review standards. In fact, if the intermediary can demonstrate that the ratio is unfair due to circumstances beyond its control, the ratio will be adjusted as exemplified by the change in the MR ratio in FY 84.

Question. It is also my understanding that data on claim reversals are not factored into intermediary performance evaluations under the Contractor Performance Evaluation Program (CPEP).

Is it true? If so, what is to prevent an intermediary from increasing initial denial rates in order to meet CPEP standards, knowing that claims may be subsequently reversed without any effect on their performance rating?

How are reversal rates monitored by the Department? Please indicate the number and percentage of denied nursing home and home health claims under Medicare for each of the past four quarters; the average time between claim denial and reversal; and the estimated administrative costs resulting from denials reversed after reconsideration the estimated costs to clients and providers attributable to successful claims appeals.

Answer. The Contractor Performance Evaluation Program (CPEP) does evaluate intermediary denial accuracy. Data on claims reversals are factored into the intermediary performance evaluation program through a series of elements which measure the accuracy of the intermediary reconsideration determinations and the accuracy of their medical review determinations. Specifically, element 3 of subsection 2901.2, Beneficiary Services, requires the intermediary to have complete documentation and proper physician review for their reconsideration determinations. Elements 8 and 9 of subsection 2901.7, Payment Safeguards—Medical review, measure the accuracy of medical review determinations, and hence denials for medical necessity reasons, made by the intermediary related to skilled nursing facilities and home health agencies respectively. The intermediary is evaluated on medical review determinations as they relate to coverage and payment.

Reversal rates are monitored by the Department through the Reconsideration Control and Management Information System (RECMIS). RECMIS is an on-line recordkeeping operation designed for the automatic processing of Medicare Part A reconsideration and hearings data. Because of the CPEP requirements and an efficient monitoring system, we do not believe intermediaries have an incentive to artificially increase denials.

Question. As a member of the House Appropriations' Committee, I asked the Department several questions earlier this year related to newly issued regulations under the Medicaid 2176 Home and Community-Based Waiver program. In response, the Department indicated that several States had expressed dissatisfaction with the new reporting requirements and that Department staff had been directed to investigate "alternatives." Please specify the status of this review, what alternatives are being considered and how States are being involved.

Answer. First, to clarify a point, the dissatisfaction expressed by several States was with regard to the current reporting instructions which are aligned to the interim final regulation. A draft reporting form which was revised in light of the final regulation has been completed by the workgroup established to investigate reporting alternatives. The draft is designed to combine the two present reports into one and to provide the baseline data necessary for us to annually verify that the legislative requirement that the waiver program be cost-effective is satisfied. A copy of the draft revised report was sent for State comment to the chairperson of the State Medicaid Group. As previously agreed, the chairperson has shared the draft with other States. To date we have received a letter outlining the chairperson's general concerns. We await specific comments which are pending receipt of the other States' input.

Question. The Department's revised regulations for the Medicaid 2176 program have been criticized on the grounds that the formula used to determine cost-effectiveness rewards States with empty beds and penalizes those with high occupancy rates and moratoriums on nursing home bed expansion. What is the Department's position on this and is this among the provisions undergoing reconsideration?

Answer. While it is unquestionably true that States differ widely in their Medicaid bed capacity, we believe that the use of bed capacity analysis under the 2176 waiver program is entirely equitable and consistent with the statute.

The legislation ~~makes cl~~ear that the waiver program is to be restricted to individuals who would otherwise require the care to be provided in a Medicaid skilled nursing or intermediate care facility. The provision of home and community-based services is cost-effective or cost neutral only when the persons receiving services would otherwise require institutional services reimbursed by the Medicaid program.

While access to home and community-based services is controlled, to some extent, by the required assessment of level of care, several States have proposed waivers in which thousands more people are estimated to need waiver services than the State could possibly serve in its long-term facilities. Further, the scrutiny of such proposals often suggests that the Medicaid waiver was being requested to refinance programs which had been funded solely by the State or by other Federal programs, for example title XX.

We believe we must deny waiver requests in which States project utilization in excess of what can reasonably be expected absent the waiver. To do otherwise would transform the waiver program from a substitutional benefit, replacing institutional care, into an expansion of Medicaid to provide new coverage of health and social services.

Our recently published final regulations point out the need to establish a reasonable estimate of utilization in nursing homes absent the waiver and require documentation in support of this estimate, including bed capacity data. This analysis did not originate in the new rules, it has been a part of HCFA's analysis program for over 3 years—a period in which over 100 waivers have been approved.

We make every effort to allow a State full credit for all the beds which it can support as available for Medicaid institutional placement, absent the waiver. We allow the State to add to its current Medicaid certified bed capacity any certified beds which have been closed as a result of the waiver program in that State.

We also permit the addition of any new or renovated beds which the State can document would become certified absent the waiver. States have been able to support claims of such additional bed capacity through documentation of approved certificates of need, State appropriations for bed development, bed renovation and conversion plans, etc. Further, we multiply the sum of all available beds by the latest bed turn-over rate which that State has reported to HCFA to recognize that more than one person, on average, is treated in an institutional bed each year.

This methodology results in what we believe is a generous estimate of the total persons for whom Medicaid could be expected to incur liability in nursing homes. We believe this may appropriately be used as an outer limit on a State's estimate of institutional utilization absent the waiver.

We believe that HCFA's application of bed capacity, because it allows for adjustments beyond the number of beds a State actually has in place, is equitable to all States both over-bedded and under-bedded. We have no plans to reconsider this aspect of the final Medicaid section 2176 rules.

OFFICE OF THE SECRETARY,
Washington, DC, Septemper 17, 1985.

Hon. EDWARD ROYBAL,
Chairman, Select Committee on Aging, House of Representatives,
Washington, DC.

DEAR MR. CHAIRMAN: In an earlier response to your June 24 letter requesting answers to several cost containment questions related to the elderly's access to long term care and community services we indicated that we would submit further information at a later date.

Enclosed are more complete answers to those questions that were only partially answered in our initial letter. We have attempted to make a best effort to provide you with the information that is available and have noted those areas where information is not available. If we can be of further assistance, please let me know.

Sincerely,

LAWRENCE J. DENARDIS,
Acting Assistant Secretary
for Legislation.

Enclosure.

Question 2. Which States are in jeopardy of losing their 2176 Waiver as a result of the Department's new requirements for Federal Financial Participation (published in the March 13, 1985 Federal Register)?

Answer. Because these new requirements are not fully implemented it will be 6–9 months in the future before we will know whether any waivers are in jeopardy.

Question 3. What steps is the Department taking to measure the collective impact of these cost containment measures under Medicare, Medicaid, Older American's Act programs and Social Service and Community Service Block Grants on the elderly's access to long-term care?

Answer. The Office of the Assistant Secretary for Planning and Evaluation is sponsoring two evaluability assessments designed to yield information on the effects of the Medicare prospective payments system on the elderly. The principal issues to be investigated are ones of quality of care and access. Questions to be answered include whether the health status of persons discharged from the hospital declined or improved and whether appropriate post-discharge services are available to meet their needs. Such indicators as length of stay, morbidity and mortality, changing family roles and quality indicators will be examined. Data sources are being identified and consideration being given to what supplemental research initiatives will be required. The resulting information and designs will enable the Department to track services utilization over time and across populations to detect patterns of post-hospitalization long-term care and their changes.

With respect to block grant information, DHHS is supporting the development of voluntary efforts to collect certain national data. The American Public Welfare Association (APWA) is administering the Voluntary Cooperative Information System to collect data on State implementation of the Social Services Block Grant. Data on the Social Services Block Grant will be available later this year. In addition, the National Association of State Community Services Programs (NASCP) is collecting data on State implementation of the Community Services Block Grant. Comparative data from the 1983 and 1984 NASCP surveys will also be available later this year.

Question 4. What data are currently available on changing utilization patterns of Medicare, Medicaid, Older American's Act, and Social Service and Community Service Block Grants long term care and community services? At a minimum, please estimate the number of elderly beneficiaries under the nursing home, home health and community service components of these programs for each of the years 1978–1985.

Answer. Enclosed for your information are excerpts from the latest Medicare and Medicaid program data on use and costs of nursing home and home health care.

TABLE 3.12.—USE OF SKILLED NURSING FACILITIES BY AGED MEDICARE ENROLLEES, BY AGE, SEX, RACE, AND CENSUS REGION, 1978

Age, sex, race, and census region	Number of aged hospital insurance enrollees [1] (thousands)	Persons served		Reimbursements		
		Number (thousands)	Per 1,000 enrollees	Total amount (millions)	Per person served	Per enrollee
Total [2]	23,984.1	267.3	11.1	$292.8	$1,095	$12.21
Age:						
65 to 69	7,956.9	26.9	3.4	32.6	1,213	4.10
70 to 74	6,302.0	41.0	6.5	46.2	1,126	7.32
75 to 79	4,536.5	56.2	12.4	63.2	1,124	13.92
80 to 84	2,997.4	66.7	22.2	72.4	1,086	24.15
85 and over	2,191.1	76.6	34.9	78.5	1,025	35.80
Sex:						
Male	9,727.7	88.0	9.0	91.4	1,039	9.39
Female	14,256.3	179.3	12.6	201.4	1,123	14.13
Race: [3]						
White	21,289.1	245.1	11.5	266.3	1,087	12.15
Nonwhite	2,035.7	15.5	7.6	19.4	1,256	9.55
Region:						
Northeast	5,730.4	61.0	10.6	80.2	1,316	14.00
North Central	6,360.9	77.4	12.2	85.1	1,100	13.39
South	7,529.8	61.8	8.2	63.9	1,034	8.49
West	3,881.9	66.7	17.2	63.1	947	16.27

[1] As of July 1, 1978.

[2] Includes persons of unknown age.

[3] Excludes persons of unknown race.

Source: Medicare Program Statistics Branch, Office of Research, Demonstrations, and Statistics, HCFA, "Medicare: Health Insurance for the Aged and Disabled, 1976–78." "Summary—Utilization and Reimbursement by Person," in preparation.

TABLE 3.14.—USERS OF AND REIMBURSEMENTS FOR HOME HEALTH AGENCY SERVICES: MEDICARE ENROLLEES, BY TYPE, AGE, SEX, AND RACE, 1978

Type, age, sex, and race	Number of enrollees (thousands)	Users		Reimbursements		
		Number (thousands)	Per 1,000 enrollees	Total amount (millions)	Per user	Per enrollee
Total	27,164	769.7	28.3	$435.3	$566	$16.00
Type of enrollee:						
Aged	24,371	713.1	29.3	398.7	559	16.40
Disabled	2,793	56.6	20.3	36.6	646	13.10
Age:						
Under 65	2,793	56.6	20.3	36.6	646	13.10
65 to 74	14,607	266.5	18.2	150.4	564	10.30
75 and Over	9,764	446.6	45.7	248.3	556	25.40
Sex:						
Male	11,598	280.9	24.2	156.4	557	13.50
Female	15,566	488.7	31.4	278.9	571	17.90
Race:						
White	23,866	666.7	27.9	370.7	556	15.50
Nonwhite	2,570	84.0	32.1	54.2	645	21.10
Unknown	727	18.9	26.0	10.4	549	14.30

Source: Herbert A. Silverman, "Utilization of Home Health Services: 1978," Medicare Program Statistics Report, HCFA (in press).

TABLE 3.12.—USE OF SKILL NURSING FACILITIES BY AGED MEDICARE ENROLLEES, BY AGE, SEX, RACE, AND CENSUS REGION, 1980

Age, sex, race, and census region	Aged hospital insurance enrollees [1] (thousands)	Persons served		Reimbursements		
		Number (thousands)	Per 1,000 enrollees	Total amount (millions)	Per person served	Per enrollee
Total	25,103.7	247.8	9.9	331.0	$1,336	$13.19
Age:						
65 to 69	8,301.7	22.1	2.7	33.1	1,494	3.99
70 to 74	6,592.1	36.5	5.5	51.1	1,401	7.75
75 to 79	4,731.0	53.1	11.2	72.0	1,366	15.22
80 to 84	3,072.4	61.1	19.9	80.2	1,312	26.10
85 and over	2,406.5	75.0	31.2	94.6	1,261	39.31
Sex:						
Male	10,156.2	80.4	7.9	101.8	1,267	10.02
Female	14,947.5	167.4	11.2	229.1	1,369	15.33
Race: [2]						
White	22,244.2	227.0	10.2	298.5	1,315	13.42
All other races	2,160.1	15.0	6.9	24.8	1,656	11.48
Region:						
Northeast	5,915.4	53.2	9.0	80.4	1,511	13.59
North Central	6,575.8	72.5	11.0	99.0	1,367	15.06
South	7,973.9	63.3	7.9	78.5	1,241	9.84
West	4,131.9	58.0	14.0	72.0	1,242	17.43

[1] As of July 1, 1980.

[2] Excludes persons of unknown race.

Source: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA.

TABLE 3.14.—USERS OF AND REIMBURSEMENTS FOR HOME HEALTH AGENCY SERVICES: MEDICARE ENROLLEES BY TYPE, AGE, SEX, AND RACE, 1980

Type, age, sex, and race	Total enrollees (thousands)	Users		Reimbursements		
		Number (thousands)	Per 1,000 enrollees	Total amount (millions)	Per user	Per enrollee
Total	28,478.2	957.4	33.6	662.1	$692	$23.25
Type of enrollee:						
Aged	25,515.1	890.4	34.9	608.7	684	23.86
Disabled	2,963.2	67.0	22.6	53.4	797	18.02
Age:						
Under 65	2,963.2	67.0	22.6	53.4	797	18.02
65 to 74	15,214.8	323.4	21.3	221.7	686	14.57
75 and over	10,300.3	567.0	55.0	387.0	683	37.57
Sex:						
Male	12,138.6	346.3	28.5	235.9	681	19.43
Female	16,339.7	611.1	37.4	426.2	697	26.08
Race:						
White	24,955.9	826.9	33.1	561.1	679	22.48
All other racers	2,743.7	106.9	39.0	84.7	792	30.87
Unknown	778.7	23.6	30.3	16.3	691	20.93

Source: Medicares Program Statistics Branch, Home Health Agency Person File, 1980, unpublished.

TABLE 3.12—USED OF SKILLED NURSING FACILITIES BY AGED MEDICARE ENROLLEES, BY AGE, SEX, RACE, AND CENSUS REGION, 1982

Age, sex, race, and census region	Aged hospital insurance enrollees (thousands)			Reimbursements		
	Persons served	Number (thousands)	Per 1,000 enrollees	Total amount (millions)	Per person served	Per Enrollee
Total	26,114.8	243.9	9.3	388.0	- $1,591	$14.86
Age:						
65 to 66	3,515.5		7.2	11.8		
67 to 68	3,405.1		8.3	13.5		
69 to 70	3,117.7		11.2	19.5		
71 to 72	2,807.8		13.1	23.1		
73 to 74	2,540.4		17.2	284.5		
75 to 79	4,940.5	50.6	10.2	84.5	1,670	17.11
80 to 84	3,175.7	59.5	18.7	91.5	1,539	28.83
85 and over	2,612.1	76.7	29.4	115.6	1,506	44.25
Sex:						
Male	16,522.6	76.3	7.2	117.9	1,546	11.19
Female	15,887.4	167.6	10.8	270.1	1,612	17.34
Race [1]						
White	23,104.5	224.2	9.7	353.7	1,578	15.31
All other races	2,264.9	13.3	5.9	24.0	1,804	10.61
Region:						
Northeast	6,086.6	53.4	8.8	95.3	1,784	15.66
North Central	6,790.0	75.1	11.1	120.2	1,601	17.70
South	8,348.0	59.0	7.1	89.3	1,515	10.70
South	4,366.5	55.9	12.8	82.3	1,473	18.85

[1] Excludes persons of unknown race.

Source: Medicare Program Statistics Branch, Office of Research and Demonstrations, and Bureau of Data Management and Strategy, HCFA (Unpublished data).

TABLE 3.14—USERS OF AND REIMBURSEMENTS FOR HOME HEALTH AGENCY SERVICES: MEDICARE ENROLLEES BY TYPE, AGE, SEX AND RACE, 1982

Type, age sex, and race	Total enrolees (thousands)	Users		Reimbursements		
		Number (thousands)	Per 1,000 enrollees	Total amount (millions)	Per user	Per enrollee
Total	29,494.2	1,172.0	39.7	$1,099.9	$943	$37.50
Type of enrollee:						
Aged	26,540.0	1,091.8	41.1	1,011.0	926	38.09
Disabled	2,954.2	80.1	27.1	88.9	1,100	30.09
Age:						
Under 65	2,954.2	90.1	27.1	88.9	1,100	30.09
65 to 74	15,673.7	390.2	24.9	365.9	938	23.34
75 and over	10,566.2	698.6	64.3	645.1	923	59.37
Sex:						
Male	12,517.8	418.3	33.4	389.1	930	31.08
Female	16,976.4	753.6	44.4	710.8	943	41.87
Race:						
White	25,796.1	1,007.1	39.0	922.4	922	35.76
All other races	2,869.2	134.0	46.7	149.2	1,113	52.00
Unknown	828.9	30.9	37.3	28.3	916	34.14

Source: Medicare Program Statistics Branch, Home Health Agency Person File, unpublished.

TABLE 6.—MEDICAID VENDOR PAYMENTS, BY TYPE OF MEDICAL SERVICE—FISCAL YEARS 1972–1983

[Amount in millions]

Fiscal years	Total	Inpatient services in general hospital	Inpatient services in mental hospital	Skilled nursing facility services	ICF services		Physician services	Dental services	Other practitioner services	Outpatient hospital services	Clinic services	Lab & radiological services	Home health services	Prescribed drugs	Family planning services	Other care
					Mentally retarded	All others										
Ending June:																
1972	6,300	2,557	113	1,471	....	....	794	170	59	365	41	81	24	512	....	112
1973	8,639	2,660	349	1,959	165	895	926	206	81	268	237	105	25	609	....	154
1974	9,983	2,807	406	2,002	203	1,301	1,083	265	101	322	284	96	31	713	....	208
1975	12,242	3,374	405	2,434	380	1,885	1,225	339	127	373	389	126	70	815	67	233
1976	14,091	3,904	529	2,476	635	2,209	1,369	373	147	555	341	147	134	940	86	247
Ending September:																
1977	16,239	4,562	506	2,691	917	2,637	1,505	427	157	877	171	177	180	1,018	117	218
1978	17,992	4,992	665	3,125	1,192	3,104	1,554	392	144	835	197	180	210	1,082	115	205
1979	20,472	5,655	778	3,379	1,488	3,773	1,625	430	163	847	275	186	263	1,196	109	293
1980	23,311	6,412	775	3,685	1,989	4,202	1,875	462	198	1,101	320	121	332	1,318	81	440
1981	27,204	7,194	877	4,035	2,996	4,507	2,101	543	228	1,409	373	147	428	1,535	139	691
1982	29,399	7,670	974	4,427	3,467	4,979	2,086	492	226	1,438	400	160	496	1,599	133	853
1983 [1]	32,351	8,802	933	4,621	4,079	5,381	2,175	467	226	1,555	479	184	597	1,771	156	936
PERCENT CHANGE																
Ending June:																
1973	37.1	4.0	208.9	33.2	....	....	16.6	21.2	37.3	−26.6	478.1	29.6	4.2	19.0	....	37.5
1974	15.6	8.5	16.3	2.2	23.0	54.3	17.0	20.6	24.7	20.2	19.8	−8.6	24.0	17.1	....	35.1
1975	22.6	16.9	−.2	21.6	87.2	36.5	13.1	27.9	25.7	15.8	37.0	31.2	125.8	14.3	....	12.0
1976	15.1	15.7	30.6	1.7	67.1	17.2	11.8	10.0	15.7	48.8	−12.3	16.7	91.4	15.3	28.4	6.0
Ending September:																
1977	15.2	16.9	10.8	8.7	44.4	19.4	9.9	14.5	6.8	58.0	−49.9	20.4	34.3	8.3	36.0	−11.7
1978	10.8	9.4	13.5	16.1	30.0	17.7	3.3	−8.2	−8.3	−4.8	15.2	1.7	16.7	6.3	−1.7	−6.0
1979	13.8	13.3	17.0	8.1	24.8	21.6	5.2	9.7	13.2	1.4	39.6	3.3	25.2	10.5	−5.2	42.9
1980	13.9	13.4	−.4	9.1	33.7	11.4	14.7	7.4	21.5	30.0	16.4	−34.9	26.2	10.2	−25.7	50.2
1981	16.7	12.2	13.2	9.5	50.6	7.3	12.1	17.5	15.2	28.0	16.6	21.5	28.9	16.5	71.6	57.0
1982	8.1	6.6	11.1	9.7	15.7	10.5	−.7	−9.4	−.9	2.1	7.2	8.8	15.9	4.2	−4.3	23.4
1983	10.0	14.8	−4.2	4.4	17.7	8.1	4.3	−5.1	0	8.1	19.8	15.0	20.4	10.8	17.3	9.7

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[1] 1983 data are preliminary figures.

TABLE 7.—MEDICAID VENDOR PAYMENTS, BY RECIPIENTS ELIGIBILITY CATEGORY, FISCAL YEARS 1972–83

[In millions]

Fiscal years	Total	Age 65 and over	Blindness	Permanent and total disability	Dependent children under 21	Adults in family with dependent children	Other title XIX
Ending June:							
1972	6,300	1,925	45	1,354	1,139	962	875
1973	8,639	3,235	65	2,015	1,426	1,446	452
1974	9,983	3,691	80	2,388	1,694	1,704	425
1975	12,242	4,358	93	3,052	2,186	2,062	492
1976	14,091	4,910	96	3,824	2,431	2,288	542
Ending September:							
1977	16,239	5,499	116	4,767	2,610	2,606	641
1978	17,992	6,308	116	5,505	2,748	2,673	643
1979	20,472	7,046	108	6,774	2,884	3,021	638
1980	23,311	8,739	124	7,497	3,123	3,231	596
1981	27,204	9,926	154	9,301	3,508	3,763	552
1982	29,399	10,739	172	10,233	3,473	4,093	689
1983[1]	32,351	11,954	183	11,183	3,822	4,483	725
PERCENT CHANGE							
Ending June:							
1973	37.1	68.1	44.4	48.8	25.2	50.3	−48.3
1974	15.6	14.1	23.1	18.5	18.8	17.8	−6.0
1975	22.6	18.1	16.2	27.8	29.0	21.0	15.8
1976	15.1	12.7	3.2	25.3	11.2	11.0	10.2
Ending September:							
1977	15.2	12.0	20.8	24.7	7.4	13.9	18.3
1978	10.8	14.7	0	15.5	5.3	2.6	.3
1979	13.8	11.7	−6.9	23.1	4.9	13.0	−.8
1980	13.9	24.0	14.8	10.7	8.3	7.0	−6.6
1981	16.7	13.6	24.2	24.1	12.3	16.5	−7.4
1982	8.1	8.2	11.7	10.0	−1.0	8.8	24.8
1983	10.0	11.3	6.4	9.3	10.0	9.5	5.2

[1] 1983 data are preliminary figures.

TABLE 8.—UNDUPLICATED RECIPIENTS UNDER MEDICAID BY ELIGIBILITY CATEGORY, FISCAL YEARS 1972–83

[Recipients in thousands]

Fiscal years	Total [1]	Age 65 and over	Blindness	Permanent and total disability	Dependent children under 21	Adults in family with dependent children	Other title XI
Ending June:							
1972	17,606	3,318	108	1,625	7,841	3,137	1,576
1972	19,622	3,496	101	1,804	8,659	4,066	1,495
1974	21,462	3,732	135	2,222	9,478	4,392	1,502
1975	22,007	3,615	109	2,355	9,598	4,529	1,800
1976	22,815	3,612	97	2,572	9,924	4,774	1,836
Ending September:							
1977	22,831	3,636	92	2,710	9,651	4,785	1,959
1978	21,965	3,376	82	2,636	9,376	4,643	1,852
1979	21,520	3,364	79	2,674	9,106	4,570	1,727
1980	21,605	3,440	92	2,819	9,333	4,877	1,499
1981	21,980	3,367	86	2,993	9,581	5,187	1,364
1982	21,603	3,240	84	2,806	9,563	5,356	1,434
1983 [3]	21,494	3,247	76	2,956	9,418	5,467	1,325

TABLE 8.—UNDUPLICATED RECIPIENTS UNDER MEDICAID BY ELIGIBILITY CATEGORY, FISCAL YEARS 1972–83—Continued

[Recipients in thousands]

Fiscal years	Total [1]	Age 65 and over	Blindness	Permanent and total disability	Dependent children under 21	Adults in family with dependent children	Other title XI
PERCENT CHANGE							
Ending June:							
1973	11.5	5.4	−6.5	11.0	10.4	29.6	−5.1
1974	9.4	6.8	33.7	23.2	9.5	8.0	.5
1975	2.3	−3.1	−19.3	6.0	1.3	3.1	19.8
1976	3.7	−.1	−11.0	9.2	3.4	5.4	2.0
Ending September:							
1977	.1	.7	−5.2	5.4	−2.8	.2	6.7
1978	−3.8	−7.2	−10.9	−2.7	−2.8	−3.0	−5.5
1979	−2.0	−.1	−3.7	1.4	−2.8	−1.6	−6.7
1980 [2]	.4	2.0	16.5	5.2	2.2	6.4	−13.2
1981	1.7	−2.1	−6.5	6.2	2.7	6.4	−9.0
1982	−1.7	−3.8	−2.3	−6.1	−.2	3.3	5.1
1983 [3]	−.5	.2	−9.5	5.3	−1.5	2.0	−7.6

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[1] The decline in total recipients beginning in 1978 is primarily due to the declining enrollment in the AFDC program.

[2] Beginning in fiscal year 1980 recipients categories do not add to unduplicated total due to the small number of recipients that are in more than 1 category during the year.

[3] 1983 data are preliminary figures.

TABLE 9.—NUMBER OF UNDUPLICATED RECIPIENTS UNDER MEDICAID BY TYPE OF MEDICAL SERVICES OUTLINED, FISCAL YEARS 1972–83

[Recipients in thousands]

Fiscal years	Total	Inpatient services in general hospital	Inpatient services in mental hospital	Skilled nursing facility services	ICF services		Physician services	Dental services	Other practitioner services	Outpatient hospital services	Clinic services	Laboratory and radiological services	Home health services	Prescribed drugs	Family planning services	Other care
					Mentally retarded	All others										
Ending June:																
1972	17,606	2,832	40	552			12,282	2,397	1,600	5,215	501	3,523	105	11,139		2,531
1973	19,622	3,256	77	678	29	433	13,278	2,916	1,903	5,295	1,790	3,959	110	12,116		2,974
1974	21,462	3,291	72	661	39	588	14,970	3,489	2,251	5,698	1,890	4,121	144	14,240		3,841
1975	22,007	3,432	67	630	69	682	15,198	3,944	2,673	7,437	1,086	4,738	343	14,155	1,217	2,911
1976	22,815	3,551	83	637	89	724	15,624	4,405	2,846	8,482	1,283	5,239	319	14,883	1,278	2,942
Ending September:																
1977	22,832	3,768	84	641	107	754	16,074	4,656	2,963	8,619	1,664	5,494	371	15,370	1,338	3,279
1978	21,964	3,782	76	639	104	740	15,668	4,485	3,082	8,628	1,400	5,684	376	15,188	1,296	2,922
1979	21,520	3,608	74	610	114	766	15,168	4,401	3,011	7,710	1,497	5,332	359	14,283	1,206	2,682
1980	21,605	3,680	66	609	121	789	13,765	4,652	3,234	9,705	1,531	3,212	392	13,707	1,129	2,517
1981	21,980	3,703	90	623	151	762	14,403	5,173	3,582	10,018	1,755	3,822	402	14,256	1,473	2,344
1982	21,603	3,530	72	559	149	765	13,894	4,868	3,223	9,853	1,702	3,814	377	13,547	1,506	2,428
1983[1]	21,494	3,688	80	574	151	793	14,056	4,940	3,306	10,009	1,760	4,462	422	13,732	1,538	2,612
PERCENT CHANGE																
Ending June:																
1973	11.5	15.0	92.5	22.8			8.1	21.7	18.9	1.5	257.3	12.4	4.8	8.8		17.5
1974	9.4	1.1	−6.5	−2.5	34.4	35.8	12.7	19.7	18.3	7.6	5.6	4.1	30.9	17.5		29.2
1975	2.3	4.3	−6.9	−5.0	74.4	15.8	1.4	13.0	18.7	30.4	−42.6	15.0	138.2	−.7		−24.3
1976	3.7	3.5	22.4	1.1	29.0	6.2	2.9	11.7	6.5	14.1	18.1	10.6	−7.0	5.1	5.0	1.1
Ending September:																
1977	.1	6.1	1.2	0.6	20.2	4.1	2.9	5.7	4.1	1.6	29.7	4.9	16.3	3.3	4.7	11.5
1978	−3.8	.4	−9.5	−0.3	−2.8	−1.9	−2.5	−3.7	4.0	.1	−15.9	3.5	1.3	−1.2	−3.1	−10.9
1979	−2.0	−4.6	−2.6	−4.5	9.6	3.5	−3.2	−1.9	−2.3	−10.6	6.9	−6.2	−4.5	−6.0	−6.9	−8.2
1980	.4	2.1	−10.8	.2	6.1	3.0	−9.3	5.7	7.5	25.9	2.3	−39.8	9.2	−3.9	−6.4	−6.1
1981	1.7	.6	36.4	2.3	24.8	−3.4	4.6	11.2	10.8	3.2	14.6	19.0	2.6	4.0	30.5	−6.9
1982	−1.7	−4.7	−20.0	−10.3	−1.3	.4	−3.5	−5.9	−10.0	−1.6	−3.0	−.2	−6.0	−5.0	2.2	3.6
1983	−.5	3.9	11.1	2.7	1.3	3.7	1.2	1.5	2.6	1.6	3.4	17.0	11.9	1.4	2.1	7.6

[1] 1983 data are preliminary figures.

Question 4. What data are currently available on changing utilization patterns of Medicare, Medicaid, Older Americans Act, and Social Service and Community Service Block Grants long term care and community services? At a minimum, please estimate the number of elderly beneficiaries under the nursing home, home health and community service components of these programs for each of the years 1979-1985.

Answer.

Older Americans Act.—Attached are tables showing for Fiscal Years 1979-1984 the recipients for community services, including home health, under title III of the Act. This data is not available for Fiscal Year 1978. Since Fiscal Year 1985 is not yet over, data collection for this year is not yet complete.

Social Services Block Grant.—Attached are tables giving partial information for block grant services.

For Fiscal Years 1978, 1979, and 1980, before title XX was amended to become the block grant, the attached tables give general figures on numbers of recipients and expenditures for the largest service categories, including homemaker and health related services.

For Fiscal Year 1981, during the transition from formula grant to the new block grant, we do not have comparable tables.

For Fiscal Years 1982-1984, we have attached a table showing the number of States planning to provide certain categories of services under the Social Services Block Grant, as shown in their yearly pre-expenditure plans. Under the Block Grant, States are not required to provide data on specific numbers of recipients or expenditures in these plans.

OLDER AMERICANS ACT (FISCAL YEAR 1979) ESTIMATED PARTICIPATION IN SOCIAL SERVICES UNDER TITLE III PROGRAM

	Total served	Minority		Low income	
		Number	Percent	Number	Percent
Transportation	2,218,822	444,595	20	1,154,233	52
Total home services	677,584	155,440	23	404,111	60
Homemaker	[1] 153,287	30 181	20	97,048	63
Home health	[1] 106,300	27,207	26	65,354	61
Other	[1] 291,360	81,224	28	186,154	64
Legal	300,097	62,776	21	162,280	54
Residential repair and renovation	70,141	18,510	26	41,710	59
Information and referral	2,596,687	496,714	19	1,268,235	49
Escort	242,885	64,969	27	142,078	58
Outreach	1,575,573	297,287	19	785,581	50
All other	3,207,358	551,916	17	1,638,103	51

[1] New York did not provide this breakout.

Note—Weighted average of minority participants, 20 percent. Weighted average of low-income participants, 52 percent.

OLDER AMERICANS ACT (FISCAL YEAR 1980) SOCIAL SERVICES UNDER APPROVED AREA PLANS

Services provided	Total persons served	Minority served		Low income served	
		Number	Percent	Number	Percent
a. Transportation	2,258,953	648,514	29	1,321,722	59
b. Home services	700,023	129,296	18	455,670	65
Homemaker	164,972	31,771	19	119,436	72
Home health	116,917	24,392	21	78,981	68
Other	391,372	68,573	18	233,831	60
c. Legal and related counseling	416,888	82,944	20	234,082	56
d. Residential repair and renovation	107,761	20,933	19	69,771	65
e. Information and referral	5,027,774	698,020	14	2,128,207	42
f. Escort	281,873	87,177	31	190,304	68
g. Outreach	1,743,409	332,463	19	937,711	54
h. All other	5,033,240	985,313	20	2,317,141	46

Note—Weighted average of minority participants, 19 percent. Weighted average of low-income participants, 49 percent.

OLDER AMERICANS ACT—SOCIAL SERVICES PARTICIPATION

	Persons served	
	Number	Percent
FISCAL YEAR 1981		
I. Estimated Persons served:		
Service provided access:		
Transportation	4,072,998	....
Outreach	2,290,093	....
Information and referral	4,683,539	....
Other	401,921	
In-home:		
Homemaker	293,054	....
Home health aid	126,787	....
Visiting/telephone reassurance	726,638	....
Chore maintenance	167,483	....
Other	193,603	....
Community services:		
Legal	454,800	....
Escort	313,907	....
Residential repair/renovation	59,776	....
Health	820,745	....
Other	3,388,913	....
Services in care providing facilities	203,136	....
II. Estimated unduplicated persons served:		
A. Total persons served	8,885,747	....
(1) Greatest social needy	3,745,239	42.0
(2) Greatest economic needy	4,536,277	51.0
B. Total minority served	1,607,229	18.0
(1) American Indian/Alaskan Native	39,428	.4
(2) Asian/Pacific Islander	150,109	2.0
(3) Black, not Hispanic	1,052,762	12.0
(4) Hispanic	350,390	4.0
(5) White, not Hispanic	7,278,518	82.0
FISCAL YEAR 1982		
I. Estimated persons served:		
Service provided access:		
Transportation	6,834,299	....
Outreach	2,464,325	....
Information and referral	5,373,406	....
Other	946,581	....
In-home:		
Homemaker	563,029	....
Home health aid	166,909	....
Visiting/telephone reassurance	1,007,035	....
Chore maintenance	203,454	....
Other	275,260	....
Community services:		
Legal	506,977	....
Escort	380,454	....
Residential repair/renovation	77,970	....
Health	816,793	....
Other	7,135,296	....
Services in care providing facilities	485,346	....
II. Estimated unduplicated persons served:		
A. Total persons served	9,160,079	....
(1) Greatest social needy	4,076,123	44.0
(2) Greatest economic needy	4,727,926	52.0
B. Total minority served	1,653,980	18.0
(1) American Indian/Alaskan Native	46,266	.5
(2) Asian/Pacific Islander	178,264	2.0
(3) Black, not Hispanic	1,049,617	11.0
(4) Hispanic	363.007	4.0
(5) White, not Hispanic	7,506,099	82.0
(6) Other		

OLDER AMERICANS ACT—SUPPORTIVE SERVICES PARTICIPATION

	Person served	
	Number	percent
FISCAL YEAR 1983		
I. Estimated persons served:		
Access:		
Transportation	7,610,765	...
Outreach	2,172,533	...
Information and referral	5,195,661	...
Other	1,968,783	...
In-home:		
Homemaker	1,057,087	...
Home health aid	146,235	...
Visting/telephone reassurance	1,069,319	...
Chore maintenance	221,104	...
Other	329,031	...
Community services:		
Legal	474,368	...
Escort	308,895	...
Residential repair/renovation	65,999	...
Health	966,946	...
Other	9,519,752	...
Services in case providing facilities	447,692	...
II. Estimated unduplicated persons served:		
A. Total persons served	9,172,609	100
(1) Greatest social need	4,279,343	47
(2) Greatest economic need	4,704,978	51
B. Total minority served	1,625,390	18
C. Racial/ethic composition:		
(1) American Indian/Alaskan Native	40,631	(1)
(2) Asian/Pacific Islander	156,470	2
(3) Black, not Hispanic	1,074,810	12
(4) Hispanic	353,479	4
(5) White, not Hispanic	7,547,219	82
FISCAL YEAR 1984		
I. Estimated persons served:		
Access:		
Transportation	8,164,340	...
Outreach	2,189,228	...
Information and referral	5,541,794	...
Other	1,749,826	...
In-home:		
Homemaker	653,594	...
Home health aid	178,002	...
Visting/telephone reassurance	969,696	...
Chore maintenance	255,691	...
Other	338,236	...
Community services:		
Legal	490,405	...
Escort	358,095	...
Residential repair/renovation	86,579	...
Health	977,000	...
Other	9,981,245	...
Services in care providing facilities	398,120	...

OLDER AMERICANS ACT—SUPPORTIVE SERVICES PARTICIPATION—Continued

	Person served	
	Number	percent
II. Estimated unduplicated persons served:		
A. Total persons served	9,126,122	100
(1) Greatest social need	4,503,912	49
(2) Greatest economic need	4,262,782	47
B. Total minority served	1,597,589	18
C. Racial/ethic composition:		
(1) American Indian/Alaskan Native	58,348	1
(2) Asian/Pacific Islander	133,053	1
(3) Black, not Hispanic	1,034,958	11
(4) Hispanic	371,230	4
(5) White, not Hispanic	7,528,533	82

GRANTS TO STATES FOR SERVICES, TITLE XX OF THE SOCIAL SECURITY ACT, FISCAL YEAR 1978

The 10 services provided to the largest number of primary recipients during 1978 are noted below:

10 services to largest number of primary recipients

Service:	[1] *Average*
Counseling services	549,200
Day care for children	[2] 435,700
Family planning services	415,600
Protective services for children	394,100
Health-related services	359,400
Case management	226,700
Homemaker services	224,100
Transportation services	189,500
Education and training services	188,700
Chore services	158,400

[1] Average number of primary recipients each quarter.

The 11 services for which expenditures were largest during FY 1978 are listed below. These services amount to 79 percent of all expenditures under title XX. Child day care was the source of the largest expenditures. For all other services, expenditures range from $3.7 million for transitional services, to $86 million for placement services, as shown in Appendix L.

11 largest services, by cost

Service:	*Expenditures*
Day care for children	$731,347,000
Homemaker services	323,408,000
Protective services for children	266,349,000
Counseling services	241,710,000
Education and training services	209,467,000
Foster care for children	196,858,000
Chore services	155,588,000
Residential care and treatment	142,112,000
Health-related services	110,540,000
Employment-related services	97,990,000
Protective services for adults	95,820,000

TITLE XX OF THE SOCIAL SECURITY ACT—GRANTS TO STATES FOR SERVICES, FISCAL YEARS 1979 AND 1980

TABLE 2.—ANNUAL COST OF THE TITLE XX SOCIAL SERVICES WITH THE HIGHEST EXPENDITURES, FISCAL YEARS 1979-80

	Fiscal year—		Percent increase or decrease
	1979	1980	
Types of Services:			
Day care for children [1]	$738,562,532	$743,391,111	+1
Homemaker services [1]	391,596,375	410,928,036	+5
Protective services for children [1]	351,774,534	383,116,468	+9
Counseling services [1]	251,879,569	239,913,425	-5
Foster care for children [1]	196,429,236	219,896,386	+12
Education and training services [1]	179,928,191	196,074,861	+9
Chore services [1]	173,864,703	195,616,686	+13
Residential care and treatment	169,561,606	181,151,782	+7
Protective services for adults [1]	108,905,541	104,154,875	-4
Placement services [1]	98,827,477	126,649,440	+28

[1] 1 of 12 services provided to the largest number of primary recipients. See table 3.

Table 3 below ranks the 12 services provided to the greatest number of primary recipients during fiscal year 1979 and 1980.

TABLE 3.—12 SERVICES PROVIDED TO THE LARGEST NUMBER OF PRIMARY RECIPIENTS

	Fiscal year—		Percent change
	1979	1980	
Services:			
Counseling services [1]	543,000	577,900	+6
Family planning services	506,300	563,200	+11
Protective services for children [1]	448,400	483,200	+8
Day care for children	422,300	437,000	+3
Health-related services	396,800	283,900	-28
Case management	260,200	293,100	+13
Homemaker services [1]	248,600	275,500	+11
Transportation services	181,700	168,800	-7
Education and training services [1]	163,200	145,600	-11
Protective services for adults [1]	151,300	147,600	-2
Foster care for children [1]	144,600	135,700	-6
Chore services [1]	134,500	129,500	-4

[1] 1 of 10 services with the highest expenditures. See table 2.

TITLE XX OF THE SOCIAL SECURITY ACT—SOCIAL SERVICES BLOCK GRANT, FISCAL YEARS 1982-85

TABLE 4.—COMPARISON OF THE NUMBER OF STATES OFFERING SELECTED SERVICES FOR FY 1982-85

	Fiscal year—			
	1982	1983	1984	1985
Services:				
Adoption	43	36	38	37
Counseling	48	30	28	32
Day care:				
Adults	41	37	29	26
Children	54	50	50	52
Disabled services	24	36	36	39

TABLE 4.—COMPARISON OF THE NUMBER OF STATES OFFERING SELECTED SERVICES FOR FY 1982-85—Continued

	Fiscal year—			
	1982	1983	1984	1985
Service—Continued				
Employment, education, and training	40	28	31	31
Family planning	47	35	31	33
Foster care:				
Adult	18	25	20	16
Children	36	34	34	33
Health related services	37	26	23	27
Home based services [1]	54	51	51	55
Home delivered/congregate meals	28	23	24	24
Housing services	22	14	12	13
Information and referral	52	36	34	37
Legal services	20	17	16	18
Placement services	27	18	13	19
Prevention and intervention services [2]		11	28	26
Protective and emergency:				
Adults	48	44	45	42
Children	52	52	47	46
Residential care/treatment	23	19	26	24
Special services for children and youth		19	24	22
Social support services [3]		27	30	30
Substance abuse services	14	7	14	145
Transportation services	36	25	25	29
Services for unmarried parents	15	5	27	35
Other [4]		5	27	35

[1] Home Based Services include: Homemaker, chore, home health, companionship, home maintenance.

[2] Prevention/intervention services include: Investigation/intervention, assessment, family centered early intervention, home evaluation and supervision, preventive and restorative.

[3] Social support services include: Socialization, recreation, camping, physical activity, living skills (money management, day treatment, family development, social adjustment, community living services, family management, life skills, education, personal and financial management.

[4] Other services include: Services to jail inmates or status offenders, social services in correctional facilities, parole supervision, diagnostic and reentry services to ex-offenders, work release, group home care, day treatment, and services to Hispanics.

Note.—N = 55 Include 50 States, the District of Columbia, and the 4 eligible areas.

Question 5. Despite the increasing demand for nursing home and, by extrapolation, home health services, a recent survey undertaken for the Committee of Medicare providers indicates that denial rates are increasing.

Does the Department have data suggesting otherwise? How do you reconcile increasing numbers of long term care claimants and heavier care needs with increasing denial rates?

Please also provide estimates of denial and reversal rates for Medicare and Medicaid claims for long term care services between 1978 and 1985.

Answer. No. Current available data indicate Medicare denial rates are increasing for both SNF and HHA services. Denial rates (measured in terms of denial notices expressed as a percentage of claims processed) for the first year of recorded experience (Fiscal Year 1979) through the most recent period for which data are available (first 6 months of Fiscal Year 1985) are shown below.

	SNF	HHA
Fiscal year:		
1979	30.3	1.9
1980	33.9	2.2
1981	35.5	2.2
1982	33.5	1.5
1983	30.6	1.2
1984	31.9	1.6
1985 [1]	33.1	2.0

[1] 1st 6 mo. only.

A factor contributing to the relatively high SNF denial rates shown above is that there are a number of States that require SNFs to submit routinely their claims to Medicare first before the claims can be considered for payment under the Medicaid program. For example, one such State is New York where the denial rate for Medicare SNF claims was about 57 percent in Fiscal Year 1984. New York's Medicare SNF denials accounted for about 22 percent of the national total and therefore had a significant impact on the national statistics in this area.

No denial data are available for Medicaid SNF and HHA services.

SNF AND HHA RECONSIDERATIONS AND REVERSALS

Fiscal year	Reconsiderations	Reversal/ partial reversal	Percentage
SNF:			
1983	13,374	2,068	15.5
1984	24,030	3,212	13.4
1985	12,226	2,009	16.4
HHA:			
1983	2,483	462	18.6
1984	4,970	1,090	21.9
1985	3,193	671	21.1

Note.—Data are not available prior to 1983. Fiscal year 1983 data may be unreliable because of systems changes and the fiscal year 1985 data consists of only cases in the system to date. September 4, 1985.

The CHAIRMAN. The Chair now recognizes Mr. Regula.

Mr. REGULA. Thank you, Mr. Chairman. First of all, I would like unanimous consent to insert into the record the statement of Congressman Hammerschmidt at this point.

The CHAIRMAN. Without objection it will be ordered.

[The prepared statement of Mr. Hammerschmidt follows:]

THE PREPARED STATEMENT OF REPRESENTATIVE JOHN PAUL HAMMERSCHMIDT

Mr. Chairman, although I don't possess any empirical data, discussions and anecdotal information from my State of Arkansas' Medical Services and Human Services Departments indicate that there's been a greater need for home health services since the implementation of the prospective payment system.

Officials in our title XX office did not have a precise client count but they are trying to respond to a trend that necessitates more home health care and attendant care services. Title XX funds have decreased almost 19 percent in Arkansas since the block grants were instituted in 1981. The money for these increased home health services has had to come from the transfer of funds from the Low Income Energy Assistance Program. Additional home health moneys have come from a reassigning of funds from the title XX socialization programs which provide group meals, counseling, casework, and social activities to a healthier group of low income older persons.

You might be interested to know that the State of Arkansas has not applied for the 2176 waiver program; this was not due to a lack of need or interest.

Before the waivers, States were restricted by statutory language which precluded most kinds of community care. The importance of the waiver, as it was established in the law, was that it would provide States with an opportunity to develop better community care services and diminish the institutional bias that is inherent in the Medicaid Program. But, as I understand it, the regulations, particularly the March 13th final regulations, contain so many restrictions, require so many assurances and so much documentation they make the entire program infeasible. As an original cosponsor of the Medicaid Community Care Act, on which this provision was based, and a strong supporter of home health care, I find this final product a great disappointment.

I have been in touch with one of the area agencies on aging in my district that has kept precise records on its provision of home health care and related services over the past 3 years. Although the director could not say that all the increased demand for services could be attributed to the prospective payment system, there was a strong sense that it accounted for a significant part of the increased utilization. I would like to place these figures, which clearly demonstrate increased need, in the record.

In the category of case management: in 1982—2,337; in 1983—2,751; in 1984—3,216 clients.

In the category of home delivered meals: in 1982—71,854; in 1983—89,509; in 1984—113,616 home delivered meals served.

In the category of personal care clients: in 1982—1,317; in 1983—1,396; in 1984—1,822 clients.

Mr. Chairman, I commend you for holding this hearing which gives us a good opportunity to look at a variety of programs which have the potential to improve the elderly's access to long-term care and community services. I look forward to hearing from our expert witnesses about their experiences with these programs and to hear their recommendations for ways to improve them.

STATEMENT OF REPRESENTATIVE RALPH REGULA

Mr. REGULA. I commend you for calling this hearing, Mr. Chairman. I think that health care for the elderly is one of the frontiers in terms of the services needed. It has much potential because it meets the concerns of the elderly. It meets their concern for wanting to stay in their homes as long as possible. If they have support services from the community, both social and medical, they have the potential for staying in a home environment for a longer period of time.

During the July recess I had a senior citizens seminar and one of the concerns expressed at that hearing was a need for more home health care, and particularly for care where patients are discharged at an early point in an illness. The implementation of the DRG Program has resulted in many instances of seniors leaving the hospital environment, perhaps earlier than they should and as a result it is important that there be home care facilities available.

Also, I think it is important that we give the States and local communities greater flexibility in implementing the Medicare Programs. I suspect that if we were to do this, we would find some innovative work being done by States in an effort to not only improve the quality of care, but at the same time reduce the cost. So the potential of this hearing is great.

I look forward to hearing from the witnesses. I yield back.

The CHAIRMAN. Thank you very much.

I have several statements submitted by members of the committee that I would like to have inserted in the record at this point. Hearing no objection, so ordered.

[The prepared statements of Representatives Bonker, Lloyd, Oakar, Synar, Skelton, Hertel, Manton, and Snowe follow:]

PREPARED STATEMENT OF REPRESENTATIVE DON BONKER

Mr. Chairman, I congratulate you for calling this hearing today which is both timely and a matter of great importance to our older citizens. As a long time member of this Committee, I welcome this opportunity to voice my concerns about recent health care cost containment measures and the impact these measures are having on our elderly population.

Clearly, our nation faces the dilemma and complexities of providing for a growing number of older people who are living longer and healthier lives, yet in need of access to acute and in many cases, chronic health care services. The runaway inflation of health costs in this country, and the impending insolvency of the medicare trust fund have compelled many of us in Congress to reassess both the way health care services are being provided to older people, as well as the method of reimbursing for such care. Cost savings measures are necessary, but I am equally concerned that recent cutbacks and regulatory changes that have been proposed may be short-sighted and, in the long run, represent an approach that is "penny-wise and pound-foolish." In our efforts to contain costs, we may be limiting access to the continuum of health care and community support options. Options which are essential in order to reduce or—at the very least—delay the more expensive institutional care alternative.

Over the past four years, the Medicare program has been a prime target for budgetary savings and regulatory reform. The most recent change will directly affect home health reimbursement that assist homebound older citizens to get back on their feet. I find it ironic that such harsh changes are being proposed at a time when we are attempting to reduce the length of stays in hospitals and rely more heavily on the services of home health agencies. The enactment of the Medicare Prospective Payment Plan System, (PPS), as documented by the recent GAO report, has indeed reduced hospital days. At the same time, however, the data show that the PPS has increased the number of frail older patients who are in need of home health services. What will happen when more and more older people are released into the community with fewer and/or more restrictive health care options?

From my own state of Washington, I have witnessed the success of the Comprehensive Options Program Entry System (COPES), a Medicaid 2176 Home and Community-based waiver program. COPES currently serves over 1500 clients in the State, and provides the opportunity for these clients to undergo a comprehensive assessment, followed by a carefully engineered plan of care. Services range from personal care to the more intensive daycare and congregate care programs.

In spite of the perceived success of this waiver program, I am concerned that the regulations published in March may seriously hamper its effectiveness. Additionally, we have learned that states are encountering great difficulties in applying for and renewing waivers. Congress desinged the 2176 waiver option to provide states with the flexibility to created community-based alternatives that would keep older persons out of nursing homes. I fear that HCFA regulations fly in the face of Congressional intent and have created a bureaucratic tangle for the states who are attempting to develop such effective programming.

I have reviewed much of the quantitative data concerning the savings resulting from these cost containment measures. Our present concern, however, must focus on the qualitative aspects of these measures—"the human impact" on those beneficiaries who are seeking access to community health services. I look forward to hearing our witnesses today address these issues.

PREPARED STATEMENT OF REPRESENTATIVE MARILYN LLOYD

Thank you, Mr. Chairman: As this Committee well knows, I have consistently opposed any reductions in benefits received by this nation's elderly. And naturally, I oppose reductions in Medicare benefits.

Our older citizens deserve better. Every year, these people are caused anxiety, when the budget or deficit reduction issues are being examined. It is at these times each year, that searches for savings lead to a call for reductions in Social Security—reductions in Medicare.

I think the time has come for us to realize that cutting benefits for our senior citizens is not the solution to our deficit problems. These people have made their contributions to the programs.

In 1980, the average Social Security payment for a married retiree was $513. In 1985, the deductible form Medicare is $400. In addition, 20 percent of all professional services, i.e. doctor's fees and professional fees for x-rays and laboratory work, are obligations of the patient. Hence, a minor hospital stay of say, five days, can cost a retiree all of that month's income plus some of his savings. What is he expected to live on?

Granted, many of us could be wiped out by an extended hospital stay, but most of us are earning a living—and probably have better health care coverage than Medicare provides. Retired persons are on fixed incomes, the only raise they can hope for is through us, and yet we are the ones talking about reductions every year. Surely there is a better way to treat our elderly.

Additionally, projections indicate that the Medicare deductible will go up to $470 next year.

We all know that a lot of Social Security/Medicare recipients have supplemental insurance. But those that don't are generally those who can't afford it. If they cannot afford the premiums for supplemental insurance, how on earth can they afford their portion of medical bills if they get ill?

We must care for our older citizens. We must consider other alternatives for saving money. Dollars is not the only element in this issue. The bigger, more important element is people. These people deserve our full support and fighting abilities. Let's see that they get them.

PREPARED STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Thank you Mr. Chairman: I want to commend you for convening this hearing today on health care cost containment efforts and their impact on the elderly.

Certainly, there can be no question that health care cost inflation must be controlled. Our country today devotes more than 10 percent of the gross national product to pay for health care. For elderly and low income persons, health care costs impose an even greater financial burden. Inflation has eroded Medicare coverage to the point where seniors now spend more than 15 percent of their income on health care, the level they were spending before Medicare existed. For the 30 million poor and unemployed Americans who have no medical insurance at all, health care is completely unaffordable and dangerously inaccessible. Health cost containment is absolutely essential if we are to guarantee access to care and ensure the affordability or our public health programs.

However, in our effort to control costs, we must guard against two very severe dangers. First we must make certain that our cost containmemt reforms do not inadvertently create new barriers to health care. An example of what can happen in this regard can be seen in the new Medicare hospital reimbursement system. The Medicare prospective payment system has begun to slow the growth in Medicare hospital spending, in part by encouraging the earlier discharge of elderly patients from hospitals. With the onset of prospective payment, though, we have not seen sufficient expansion of Medicare home health services to ensure adequate care for newly-discharged patients who must complete their convalescence away from the hospital. It is fine to save costs by discouraging institutional care when it is not necessary. At the same time, however, we must ensure that care which is necessary—in the home or the community or in some other setting—is also available.

The other danger we must guard against is losing sight of the real purpose of cost containment. In the last five years, the Reagan Administration has used cost containment as an excuse to justify harmful cuts in Medicare benefits and eligibility—cuts that ultimately will lead to higher costs. Recently, we have seen the President's budget proposal to increase copayments for home care under Medicare, a move that would discourage the use of this needed and cost effective care. In addition, we have seen the Administration's latest order to reduce Medicare reimbursement to home care providers. In my own district, the Administration's new reimbursement formula could reduce the availability of home care services by up to 10 percent. We must allow these kinds of attacks on the Medicare program to hide behind the name of cost containment. Our senior citizens deserve constructive solutions to protect their health care program, not destructive proposals to obliterate it.

Mr. Chairman, I am confident that, under your fine leadership, we will continue to make progress toward making health care for the elderly both more accessible and more affordable. I appreciate the contribution of this hearing in that regard, and I look forward to hearing the statements of our distinguished witnesses.

PREPARED STATEMENT OF REPRESENTATIVE MIKE SYNAR

Mr. Chairman, I am pleased to participate in these hearings today. As this Committee heard in February, there is a lack of information about how the changes in medicare reimbursement practices are affecting the availability of quality health care for senior citizens. The information we hear today will be invaluable to the Committee and the Task Force on the Rural Elderly as we address this issue.

As Chairman of the Task Force on the Rural Elderly, I am particularly concerned about the lack of long-term care facilities in rural areas and the increased demand for these services as a result of PPS and DRG's. The survey the Task Force on the Rural Elderly as we addreess this issue.

As Chairman of the Task Force on the Rural Elderly, I am particularly concerned about the lack of long-term care facilities in rural areas and the increased demand for these services as a result of PPS and DRG's. The survey the Task Force released during February's hearing showed that over 50% of state aging offices responding believe that existing skilled nursing care is not adequate to meet the needs of discharged patients in rural areas. Over two-thirds of the respondents said that nursing homes don't have adequate personnel to provide care in rural areas since the implementation of PPS.

I'm concerned that reimbursement freezes and the proposed waiver of liability provisions are limiting the quality of care and services that nursing homes and home health providers can afford to offer. We should be encouraging this much-needed health care service, instead of discouraging providers from participating in the few public programs that cover long-term care services.

I want to thank all of our witnesses for taking the time to appear before the Committee today. I am looking forward to hearing what they have to say about this important problem.

PREPARED STATEMENT OF REPRESENTATIVE IKE SKELTON

Mr. Chairman, in late March I chaired a hearing of the Health and Long-term subcommittee in my district that examined how Medicare's prospective payment system and related programs are affecting the medical care Missouri's senior citizens receive. My colleague Tom Tauke and I heard about many serious problems, like rules which require senior citizens from rural areas to return home the same day they undergo physically exhausting diagnostic procedures, regardless of the distance they have to travel and the availabilty of family members to assist them. The testimony we heard that day convinced me that, despite our clear intentions, changes we made in the Medicare program are adversely affecting the quality of care provided to our senior citizens.

Why is this? After all, we took great pains to include safeguards that, together with fair payment rates, should have prevented many of the problems we will hear about today. I believe the answer lies in an over-zealous bureaucracy which is using the changes we made to improperly cut Medicare expenditures without regard to the effect those cuts are having on our senior citizens. Indeed, those currently charged with administering the Medicare program recently pouted publicly in the Federal Register because a federal judge ordered them to issue rules implementing a provision of the law which requires payment adjustments for hospitals that serve disproportionately high numbers of the elderly and poor.

Mr. Chairman, it is most appropriate that we are holding this hearing just days before we mark the 20th Anniversary of the Medicare program. I believe the interest we show in the problems senior citizens are encountering reaffirms our commitment to assuring that the gains Medicare has brought in the access of older Americans to affordable, high-quality health care will not be sacrificed as we continue our effort to control the costs of the program.

PREPARED STATEMENT OF REPRESENTATIVE DENNIS M. HERTEL

As this committee begins to review the effect of health care cost containment of the elderly, I want to highlight an industry which, while well suited to assit the elderly in their own homes, is restrained by recent changes in the Medicare program. The industry I refer to is the home care medical equipment suppliers. My constituent, Mr. Sanford J. Linden, President of Linden Home Health Care, Inc. has brough to my attention the effect of these changes on the elderly. Mr. Linden is also the current President of the National Association of Medical Equipment Suppliers, which has prepared a statement identifying the effect on beneficiaries of the recent and proposed Medicare durable medical equipment benefit changes. Mr. Chairman, I ask that the NAMES statement be admitted to the record and thank you for the opportunity to provide my opening remarks.

PREPARED STATEMENT OF REPRESENTATIVE THOMAS J. MANTON

Mr. Chairman, I would first like to commend you for holding today's important hearing. In February we heard testimony regarding the impact of the prospective payment system and D.R.G.'s on the quality of health care. I'm pleased that the committee is continuing its examination of the impact of cost containment of the quality of care given to older Americans.

As we have heard many times in this committee, and as I have heard often from my constituents in New York, one the major effects of the prospective payment system has been the early discharge of patients from hospitals. As a result, there has been an increase in the need for alternative or additional care at nursing homes and home health care centers. However, despite the increased health needs of older

Americans, there have been a number of budget cutbacks which limit the ability of States and local communities to provide alternative care. Several new regulations for Medicare and Medicaid have made it increasingly difficult for providers to participate in programs that cover long term care sevices. In addition, according to information provided by the chairman, regulations proposed by HCFA would further discourage partial or full participation of providers in the Medicare system. I am concerned that while older Americans are leaving hospitals sooner, the long-term care system's ability to provide services is being weakened by the administration's actions.

We all recognize the importance and the need for health care cost containment. It is essential that the administration and the Congress take responsible steps to address the problem. However, we must rejected cost containment measures that result in limited access for older Americans to essential services.

I recently received a letter from a constituent who works in the health care field. One of her concerns was the shortage of long term care facilities within the community. I believe that her question is one that is particularly relevant to today's hearing. If the administration continues on its present course, will my constituents' access to health care services be further limited?

Mr. Chairman, the cost of health care has increased dramatically as has the amount of our Nation's resources spent on health care. In 1960, health care made up 5.3 percent of the gross national product. By 1982 that figure had almost doubled to 10.5 percent. In 1982 the Federal Government paid 68 percent of the share of public health expenditures, largely through Medicare and Medicaid. Clearly, then, we have a responsibility to control health care costs. However, these measures must not result in older Americans being deprived of important health and social services. While I agree with the administration's desire to contain health care costs, I am opposed to measures that result in denying older Americans needed and rightful health care coverage and limits their accessibility to essential services.

PREPARED STATEMENT OF REPRESENTATIVE OLYMPIA J. SNOWE

Thank you, Mr. Chairman for holding these hearings on health care cost containment. Increasingly, the issue surrounding health care and our ability and willingness to pay for care are becoming topics of great concern.

In 1983, health care expenditures in the United States totaled over $355 billion, an average of $1,459 per person and about 11% of the gross national product. In that same year, the Department of Health and Human Services implemented cost containment measures for hospitals based on diagnosis related groups (DRGs). As a result of DRGs, the rate of inflation of hospital costs has decreased for the first time since the implementation of wage and price controls in 1972 and 1973. Thus, it appears that the DRGs have been successful in containing costs.

Quality is not so easily measured, however. We have heard from the General Accounting Office and from those of you who provide the needed services in our communities that the elderly are being released "sicker and quicker". We do know that the average stay per patient is down significantly and it appears that the majority of the cost savings in hospitals is based on the diminished stay per admission. The question then becomes, are those who are released earlier being released too early, or is it simply that hospitals were keeping patients too long prior to the implementation of the DRGs. Clearly what we do not want is an inappropriate cost shifting to community based care if the patient is not appropriately suited to being cared for outside of the hospital.

Additionally, there has been concern that the DRGs do not permit enough latitude in the care of the older patient. On July 4th, in the Washington Post an article appeared in which a Johns Hopkins researcher indicated the need for DRGs to include a measure of severity. In my own state of Maine, many questions have been raised about the need of DRGs to take into consideration the rurality of an area. Others have suggested that DRGs should be more sensitive to age factors and other issue that increase risk.

I am pleased that we can continue the dialogue that was begun in February of this year. I think it is important that we sort out the effects of the DRGs and the extent to which quality care can be delivered under a system of cost containment.

The CHAIRMAN. The first witness this morning is going to be the Honorable William Donald Schaefer, who is the mayor of the city of Baltimore. He is here also representing the U.S. Conference of Mayors.

Mayor Schaefer, would you please proceed in any manner that you may desire?

[Due to the fact Mayor Schaefer chose not to use a microphone, his testimony may appear garbled because of the inability of the reporter to record it.]

STATEMENT OF HON. WILLIAM DONALD SCHAEFER, MAYOR, CITY OF BALTIMORE, MD; REPRESENTING THE U.S. CONFERENCE OF MAYORS

Mr. SCHAEFER. Thank you very much, Mr. Chairman, and let me say that I am—I was going to say that I am delighted to be here. I am also elected, so I wonder if it is a delight to be here or not.

I am here to talk about the elderly today, here to talk about the poor and those who are in need. I am not going to say anything that you don't already know. I am not going to give you any pearls of wisdom. I am not going to tell you anything that you haven't really seen if you have seen people in your communities. I am not going to give you anything new. I am just going to say to you revenue sharing—I cry my heart out when Congress was giving our revenue sharing away, $17 million that we will have to make up for the tax base, the highest in the State.

And now I am here to talk about the poor. And I am here to talk about the elderly and the needs of the elderly and where to go from here.

With your permission, rather than reading a statement, I would like to refer to some charts and tell you some of the facts about the city of Baltimore as I see them—about the poor and elderly as I seem them and about the concern that I have and what can we do.

When the Governor comes and he wants to interrupt me, I will be more than glad to sit down, because I would like to hear the testimony of the Governor and hear what he has to say. So it won't make me feel bad if you say, "Mayor, sit down and let the Governor speak." That will be OK.

Today I drove from my home down Mulberry Street, and I looked to the left and to the right, and there was a Catholic charity agency. In front of it were four or five women, homeless women; some of them ages 50, 55, and 60. I see one woman there every day, every day. She needs help—medical help, psychological help, whatever it might be, the Catholic charity is providing.

I thought about her, and I thought what can I do? I think about the State of Maryland that said we are going to take all of the people out of the mental institutions who shouldn't be there because the law shouldn't keep them in, and then we are going to send them out into the community right down to Baltimore City, right down to the city where there is no followup, no one to follow what has happened to those people, and I have concern about that.

Last night, I discussed my appearance before your committee with the Health Commissioner. The Health Commissioner is Dr. Susan Guarnieri. And I saw her worried. I saw her concerned. I saw her frustrated, and I saw her concern because she was worried about the elderly and what was happening to them medically. And I worried about what was happening to them medically, but I also worried about what was happening to them as far as food was concerned. I also worried about them on housing. I also worried about them on transportation. There are a lot of problems; we are going to center on medical problems of the elderly today.

The problems of the elderly are not new. We, the health commissioner, all of us, are working hard to make sure that we all live longer. We all want to live longer, but with our length of living, there should be some peace of mind, some feeling that if I live longer, I am not going to have to worry myself to death about whether I have a house, whether I have medical care, whether anybody cares about me.

After speaking last night with Dr. Guarnieri, I thought about me. I am a senior citizen. I live in my own house. I live alone. If I get sick and I go to the hospital and I am sent home, and I am in need of care, who do I go to? Who will come in and say to me, "I'll put the drops in your eyes." Who will come over to me and say, "I'll see that your pill is taken care of." Who will come over to me and say to me, "Schaefer, I'll take care of the food." And I thought about me last night, and I thought about all of you. Everyone here is going to get older. I see all of these young people today, and I see all of them standing around, and I think your knees don't hurt you yet. You don't have that difficulty of stepping up on the curb. There isn't arthritis in your fingers. Then my thoughts turn again to the elderly. I worry about their aches and pains and what can we do for them.

We must walk. We must bathe. We must dress. We must shop. We must eat. We must worry about our medical problems. Then, last night, I again said to myself, what am I going to say when I go to Washington? You have got so many problems, and I coming over and I am going to give you another one. I am going to tell you about the problems of the elderly and the poor. And you have got problems running out your ears. You have got problems with the budget. You have got problems of defense.

OK, let's take a look at Baltimore.

Nationally, the data shows a tremendous growth in the elderly population in the next several decades. You know that. In Baltimore City the elderly population is large. Already our 65-year-old population is 13 percent of the city's total population. That is 100,000 people. By 1990 it will be 106,000, about 15 percent. Twenty percent of Maryland's elderly live in Baltimore City. The elderly population is growing older. In the 1980's alone, the population over 75 grew by 19 percent. In 1980 it was 39,000. In 1985 it was 46,000.

Unfortunately for Baltimore, this is where the elderly poor congregate. And you don't say, well, they are your poor. Take care of them. Why should you ask anybody else anywhere else to help you take care of the poor?

Eighteen percent of the elderly population has incomes below the poverty level of $4,400. Forty percent of Maryland's poor live, again, in Baltimore City. The very poor and the near poor are the people who are the biggest problems getting access to needed care.

Now how are the elderly going to pay for the needed services? Look at some of the changes in the past year. When the Medicare Program was enacted in the sixties, some people thought it would be the answer to the elderly's medical problem. Today, under Medicare, a hospital stay costs almost 200 percent as much as it did in 1981—$204 in 1981, $400 in 1985.

Pressure is being put on hospitals to reduce costs through shorter hospital visits. There is a problem that I will get to in a moment.

Overall the Medicare Program, which was developed to take the burden off the elderly for health costs now only pays 44 percent of the total health care costs for the elderly.

Chart No. 3 talks about Medicaid. There were $4 billion in cuts nationally in 1981 and 1982 under this program. In addition, more pressure has been put on Medicaid to pick up the cost of cuts in the Medicare Program. Thirty-six percent of Maryland's Medicaid Program is now being paid for by the elderly, $222 million for 65 and older. Maryland's Medicaid Program is struggling and not succeeding. This program was originally designed for the poor overall, and it is now a fact that Medicaid can't pay for it all.

All right, who needs help? The elderly getting out of the hospitals. Why are they getting out of the hospitals? Because hospitals have a financial incentive to send them home. Sickly elderly go home from the hospital before they are ready to go home, and to homes not equipped to handle them. And I use the example of the Mayor of Baltimore City. If I go home, there is no one there to care for me. What happens to me? If elderly people are to be released early from hospitals, we must at least provide medical care as soon as the patient leaves the hospital.

Chart No 4, what else is happening to the elderly? Hospital costs. Two-sided coin—hospital costs going up, length of stay going down. Demand for home health care going up, and please don't misunderstand me. I am all for getting people out of hospitals as soon as they are able. Unnecessary hospital stays represent costs that can and should be cut, demand for community service going up as well.

What else is happening to the elderly? Senior citizen centers—the budgets are frozen. Transportation cost subsidies for the elderly are frozen. Less trips to the store, to the recreation centers, to nutrition programs Housing for the elderly is virtually curtailed. All those problems are problems of the elderly. These are the problems we are looking at.

Now, let me go to the local picture. Nursing home placement is increasingly difficult.

Susan Guarnieri tells me that nursing homes have 95 percent occupancy in Baltimore. So it isn't easy to get into a nursing home. And some people released from hospitals don't have to go to a nursing home. They can go directly to their home if there is somebody there to provide the care for them. Medicaid does not cover services adequately. The State provides only limited alternatives to Medicaid.

Let me tell you about the State. I am a mayor. I said to the Governor, "Governor, when I have a problem, I come to you. You have a problem, you go to the President." The Governor sort of laughed at me. There is a responsibility on all of us, the Federal Government, the State Government, and I can't say it is all your responsibility. I have got to do something, too. I told Dr. Guarnieri suppose you decide that you are not going to do anything; suppose the Governor just says, "I am not going to do anything," the poor, needy elderly are still there and somebody must do something.

I said to her last night, when I go, I want us to be able to say what we are doing.

The community pays for services for the elderly. If you took away the Catholic charities and the Jewish charities and all the other charity organizations, where would we be? But there is a limit to what they can do. There has to be a coordination between all of those agencies so that when an elderly person gets out of the hospital, somebody picks them up, whether it is the Jewish organization, the Protestant organization, whoever it might be.

Let me give you a couple of cases. These were Baltimore City cases. Dr. Guarnieri reported to me. OK, first a cataract patient no longer hospitalized, no after care services, sent home literally blind, literally blind. And I think again, suppose it was me. Off comes the cataract, home I go, and I have got to walk up and down the steps. No one worries about what is going to happen to me. I can't call Dr. Guarnieri every 10 minutes and say, "Susan, come out and take care of me. Tell me what I am going to do with my eyes."

Somewhere along the line, there is an answer, not to a nursing home or not longer stay, but there is an interim. And it can be done. Take my second case, an elderly couple. This couple is basically homebound, the husband is 68, suffering from emphysema, arthritis and has to use portable oxygen. Wife, 62, leg amputee, confined to a wheel chair. Both are taking prescription medication for chronic illness and are receiving home care services from the Catholic charity. They were also receiving Medicaid coverage until they applied for disability benefits to increase their income. They were terminated from Medicaid as a result of a complaint that the additional income disqualified them for Medicare.

The last one, a 76-year-old woman was admitted to a local hospital with a history of heart failure and heart disease; discharged with no in home medical assistant nor other needed services; found in home alone 5 or 6 days later, second heart attack. She now goes to the hospital for extended care. Maybe had somebody been able to get to her earlier, maybe she would have been able to be helped. I don't know. I am not positive.

All right, whose responsibility? Dr. Guarnieri said to me last night it is the State and the Federal Government. And I say, OK, suppose nothing is done, shift it back to us? My conscience will be all right because I will say it is your responsibility. My conscience will be all right because I'll say I can't do everything for you. I don't know whether you think I am concerned or not. I am. I listened to her last night. I really listened to her last night. Whose responsibility is it? Whose going to pay? Money is not enough, we don't have enough for the programs. We must keep the poor people out of the hospital. We must keep them out of nursing homes, all of which I have said before.

The people should go to their homes, special home services. Agencies in Baltimore are now providing care but not nearly enough care.

Well, let me conclude. What are we doing in Baltimore? We have a special home service care. We have a gateway program. We have channeling. We have department of social service work, all these people, but I wondered whether it is enough. And I will end by chart No. 7, recommendations.

Look beyond the dollar savings at the effect you have on people's lives. Dollar savings in the hospital—save money in the hospital, but there must be something else to be able to provide for the care of the elderly. I was going to end by saying, Susan, I want you to go home tonight, and I want you to come back with a program so I can say to the Congress tomorrow I am doing something. OK, who? The elderly over 65. Why? Home care is less expensive; for hospital care there is cost containment. When? On discharge from the hospital. How? All hospitals discharge of elderly be coordinated. Where? The city will take the lead and work with the Office of Aging.

We are going to try it. We need some money to do it. If you don't provide the money, we are going to try it anyway. We are going to see what we can do. In our country, I think we should help the elderly, help the elderly poor. I believe in this. My time is up.

I don't know whether I have made any impression on you. I don't know whether I have given you anything new. And I will tell you one thing. Dr. Guarnieri awakened me last night. We are going to look to the State. We are looking to the Federal Government. I ride down the street and I think, you know, I have got to look out for it, too. I need your help. We need some money. We need some programs.

A person goes to the hospital, and to cut out the hospital care costs, we send them home. Don't send them home and forget them. That is very simple. That is such a simple solution, why can't we do it?

[The prepared statement of Mr. Schaefer follows:]

PREPARED STATEMENT OF MAYOR WILLIAM DONALD SCHAEFER, CITY OF BALTIMORE, MD

Congressman Roybal and Members of the Committee:

Thank you for the opportunity to comment on cost containment and care for the elderly. As a local elected official, I am seeing firsthand the problems of the elderly today. I am also anticipating that in Baltimore City, as in many other urban areas, the difficulties in providing adequate resources for the elderly will grow substantially as the elderly become a larger percentage of the population. In developing health care and social service policy at the Federal level, you as decision makers must be sensitive to the needs of this growing segment of the population and to the concerns of local government. In a world of limited resources, cost-effective programs are essential. However, containing costs at the Federal level at the expense of already financially strapped localities is not an acceptable approach.

Nationally, the statistics show that there will be dramatic increases in the elderly population in the next several decades, and that the ratio of the elderly to the total population will also increase substantially. Thus, between 1980 and 2030, the population 65 and older will grow from approximately 25 million to 50 million. Whereas the population 65 and over will double during this period, the population as a whole will grow by only 40 percent.

In Baltimore City, similar trends are anticipated. Although we have not projected the elderly population through the year 2030, we can observe meaningful changes during this decade alone. The overall population is still declining through continued outmigration to suburban areas. However, the elderly population is growing and will reach 14.6 percent of the overall population by 1990. Interestingly, the elderly population is growing older! Whereas the number of elderly individuals over 65 will grow by 5 percent during this decade, the number of elderly individuals over 75 will grow by 19 percent. That is very significant when considering what the demand for services will be.

The National Center for Health Statistics has compiled data which show that of the total 65 and over population, 45.7 percent have some activity limitations and 39.4 percent have major activity limitations, meaning an inability to work or keep house. The Center has also collected data on the percentage of adults needing assistance in basic activities, including walking, bathing, dressing, toileting, eating, etc., and on those needing assistance in home management activities, including shopping, chores, meals, and financial management. For those between 65 and 74, 5.3 percent need basic assistance and 5.7 percent need home management assistance; for those 75–84, the percentages jump to 11 percent and 14.2 percent, respectively; for those over 85, there is a dramatic increase to 34.8 percent and 39.9 percent, respectively.

Another significant factor in assessing demand is income level. Unfortunately, Baltimore, like many other major urban areas, has a large poor elderly population. Eighteen percent (18 percent) have income below poverty level. The City's elderly poor represent approximately 40 percent of the elderly poor statewide. We expect to continue to have a large percentage of the State's elderly poor for some time to come.

Long range policy decisions regarding care for the elderly will have to be made based on the above demographic data. I, like other local elected officials, will need your help. The Federal government must participate in finding long range solutions and must remain a contributor of resources, both financial and technical. You must not abdicate your role in developing and supporting appropriate programs.

The probliem of providing care for the elderly, however, is also an immediate problem. What has been happeniung at the Federal level has been frightening me. As we are beginning to need more assistance, you in Washington appear to be moving in the opposite direction.

Actions taken at the Federal level during the past several years to curtail spending in health and social programs have resulted in major cost shifts to state and local levels of government, as well as to the pockets of the elderly. While I have no objections to reducing costs throgh greater efficiency, I do object when the elderly become the victims of real losses in services, and when policy changes at the Federal level do not ultimately lead to cost reductions in the overall system, but merely to a transfer of responsibility from one level of government to another.

Spending decreases and cost containment measures have begun to take their toll. The elderly are spending far more under the Medicare program than just a few years ago, for example. The Medicare deductible for each hospitalization period is now 96 percent greater than in 1981. The annual deductible for physician visits is now 25 percent higher than in 1981. The annual premium for outpatient visits has risen by 62 percent. Changes in hospital reimbursement have also had a negative impact on the elderly. Diagnose Related Group (DRG) reimbursements have given hospitals the incentive to release patients earlier and sicker.

Recent national data collected by the General Accounting Office (GAO) shows that the average length of stay, under the prospective payment system (PPS) in fiscal year 1984 was 7.5 days as compared to 9.5 days in fiscal year 1983 prior to the PPS program.[1] Site visits by GAO staff to hospitals, nursing homes, home health providers, and discharge planners revealed that patients were being released after shorter lengths of stay and sicker than they have been in the past.

In Maryland, the Medicare waiver enables the State to reimburse through a different system. Nonetheless, pressure is put on the system to contain costs in order for us to retain the "all-payer", equal access concept the waiver permits. At least according to the anecdotal information now available, hospitals in Maryland are also releasing individuals earlier and sicker than previously. Medicare covers only minimal skilled nursing benefits for patients once they leave the hospital.

It is now well understood that Medicare can no longer be considered the health care program for the elderly. Only 44 percent of elderly health care is now paid under Medicare. In fact, last year beneficiaries supposedly spent as large a share of their income on health care as they did before Medicare was enacted in the 1960's, a sobering thought!

Did you expect the Medicaid program to solve the problem of health care for the elderly? It has not done so in Maryland, and I doubt whether it has elsewhere. True, Medicaid has begun to pick up costs where Medicare is not picking up costs. Maryland's program has paid for Medicare premiums and deductibles for the Medicaid-eligible elderly population. In 1984, enrollees in Maryland over 65 represented 11.2 percent of total Medicaid eligibles, and they accounted for 36.4 of total Medicaid payments. Over 16 percent of Medicaid expenditures in 1984 were for nursing facilities.

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[1] Data submitted by the GAO to the Senate Special Committee on Aging in correspondence dated 21 February 1985.

However, even though care for the elderly may be eating a substantial portion of the Medicaid budget, the program is still not adequately addressing the needs of that population. It is still far from meeting the need for good community-based care, for example.

Although there may be some increased flexibility provided to states in how they design their Medicaid programs, the resources are not there to support the demand for services. Maryland has continued to increase its Medicaid budget annually, and has taken advantage of numerous Federal options to provide broad coverage. However, even using maximum allowable eligibility levels, the program can only cover 50 percent of the poor or near poor population.

The elderly must compete with other vulnerable groups in the population for assistance under the Medicaid program. As costs for care to the elderly shift from the Federal to State level (along with costs for care for other groups), the decisions become tougher and tougher and there is potential for increased conflict between the local and state level as to how to divide limited resources. Should we begin to provide more resources for the elderly at the expense of high risk mothers and infants and how will that be determined?

Major reductions in the Medicaid program were made in 1981 and 1982 under the Omnibus Reconciliation Act and the Tax Equity and Fiscal Responsibility Act. Since then, Congress has not supported Administration aims to make additional major reductions, but given the trends in Federal budget cutting, the future Federal participation levels in the Medicaid program are still a big question mark. Already 10 percent of Maryland Medicaid enrollees qualify through 100 percent state funded categories. In 1984, close to 60 percent of the $600 million budget was state funded. It would be unrealistic to think that the State is not wary about further expansion of Medicaid programs for services for the elderly, as well as for any other group. The threat of being left with a more substantial portion of the burden in the future is very real and very scary.

You have not only transferred the burden to us for health care, but at the same time, you have cut back other essential social programs for the elderly. The more you take away in social service programs, the more thinly spread the elderly individual's income will be, and the less likely he will be to be able to buy needed health care services. It may be cost-effective in certain instances to keep elderly people out of hospitals or other institutions (nursing homes) and to care for them in the community. It is certainly the more humane approach to caring for the elderly in many cases. But we cannot do it without adequate community support programs.

Older Americans Act funding declined significantly for a few years. Congress has sought to reverse that trend at the national level in the past few years, but funding for the Baltimore City program has not increased. Our senior center budget has been frozen for several years. Staff has had to devote more time to fundraising and less time to services in order to continue to serve the same number of clients. The transportation portion of the Older Americans Act program in Baltimore provides a good example of senior service cutbacks. The budget has been frozen. As a result, the number of trips provided for recreation, shopping, and other such purposes is declining at a rate of over 20 percent per year.

Probably some of the worst cuts have been in nutrition programs. The Eating Together program which we have relied upon to guarantee at least one nutritious meal per day to needy elderly is funded now at only 71 percent of the 1981 level. As many as 350,000 fewer meals are now being served under that program annually.

Substantial cuts have also been made in housing programs for the elderly. The Section 202 program would provide no new units in 1986 if the Administration budget proposal were adopted. Nationally, since 1979, the number of new units authorized annually has declined by 40 percent. New units under the Section 8 and public housing programs, which provide housing for the elderly, would also be virtually eliminated in 1986 if the Administration plan were adopted.

In Baltimore City, we have felt very severe impacts in elderly housing programs since 1979 when major cuts began. The number of units that have been provided annually has dropped steadily from 829 in 1979 to 104 units in 1984.

These are a few examples of cuts in services for the elderly. Other programs, which may not only serve the elderly, but which have a large percentage of elderly clients, have also suffered major setbacks. The Social Services Block Grant is slated for gradual reductions from now through 1988, according to Administration plans.

The Community Services Block Grant would be eliminated for all practical purposes.

Furthermore, still in question is the kind of cuts, which may be imposed on the Social Security program. Even small changes in cost of living increases can make changes in the income of elderly people which prevent them from being able to purchase needed medical services, nutritious meals, etc.

I cannot expect to provide adequate services for the elderly, including health care and social service support, for those who should be able to remain in the community with a dwindling Federal commitment. The state has accepted some cost shifts, but has not been able to compensate. Cuts in health care and simultaneous cuts in social services are making it impossible, and demographic data indicates that the situation will worsen. I am beginning to feel truly abandoned.

The picture for some in Baltimore is truly grim, especially for those who do not have adequate resources to sustain themselves through old age. Let us consider some basic problems. Finding good institutional care for the elderly is difficult. Nursing home occupancy rates are 95 percent to 98 percent in Baltimore, and the state, under our highly regulated system, is clearly cautious about expanding nursing home capacity, given its already taxed Medicaid budget. Many individuals, even those who have worked all their lives, cannot pay for institutional care. Medicare provides only very limited benefits. They go through a "spend down" process until they have exhausted all their resources and qualify for Medicaid.

Arranging for appropriate community-based home health care is much more difficult. For those who can pay, finding appropriate services may still be difficult, but home health services are available. For those who can't pay, many of whom are not eligible for Medicaid, the process for arranging appropriate care can be nightmarish.

Suppose the individual is sent home fairly sick from the hospital, or suppose he has been living at home and has gradually declined to the point of needing assistance to remain there. Medicare will cover very limited skilled nursing services in the home. It will not cover personal care services or chore and homemaker services which may be required for an extended period of time, if not on a permanent basis.

If the person is eligible for Medicaid, he will only get limited support. At this time for example, Medicaid is paying $10 per day for personal care services, including dressing, bathing, feeding, etc., regardless of how many hours may be required. For those who need additional support or other sources, there are a variety of other options, but the resources are difficult to secure and may not be adequate.

Limited funding is available through the State's Department of Social Services (DSS). This agency may provide for homemaker or personal care services, day care programs, and even foster care. Additionally, DSS operates the Adult Protective Services program to address the needs of the abused elderly. However, DSS is not specifically geared towards the elderly. Its overburdened staff assists only a very limited number of elderly clients and extremely few with health related home services.

The State has directed some additional resources towards case management types of services for the elderly. The Geriatric Evaluation Services (GES) gets referrals from hospitals, the community, or other social service agencies to evaluate elderly individuals, determine whether they should be institutionalized, and if not, what services and public assistance might be available to them to remain in the community. The Gateway project has case managers which attempt to direct elderly individuals to services. They also have "gap-filling dollars" available to provide limited financial assistance where it cannot be found elsewhere. Most of these resources pay for personal care, home health aides and homemaker or chore services. Gateway now has a caseload of 250. It previously had a caseload of 300 clients when it operated under a Federal demonstration grant called Channeling. While Gateway is often referred to as the major community-based care support system for the elderly, it now has a four month waiting list. It has stopped accepting any additional referrals.

The Baltimore City Health Department (BCHD) provides gap-filling services as well, where possible. The office of Special Home Services has a client caseload of over 2,000 individuals who are served by home health aides or provided with homemaker and chore services.

Some non-profit providers and charitable organizations are also picking up part of the burden, but clearly not meeting all of the demand.

The BCHD has begun to look at expanding home health services and at providing a more comprehensive case management service for the elderly which would direct people to other needed services, because it is evident that needs are not being met.

While the numbers are difficult to document precisely, the repeated stories by caseworkers and referral services clearly indicate a shortage of services. The overall picture of care for the elderly is one of great fragmentation and frustration. The needs are there for medically oriented services, but the demand is also great for additional social services.

Let us look at a few Baltimore examples. Cataract surgery must be done on an outpatient basis. There is no consideration or concern about a patient's age or physical capacity. The surgery is done without hospitalization regardless. Patients are therefore sent home literally blind. If they have a family, there my be no problem. Without some support, the person often fails to receive the proper post-op medications. The patient's nutrition, housing or other personal needs are not met.

An elderly couple is basically homebound. The husband is 68 years old suffering with emphysema, arthritis and has an oxygen supply at home. His wife is 62 years old and is a leg amputee, confined to a wheelchair. Both are taking prescription medications for their chronic illnesses and receiving homecare services from Catholic Charities.

They were receiving Medicaid coverage until they applied for SSA disability benefits and increased their family income. They were terminated from Medicaid as a result, but complain additional income is not sufficient to cover their combined medical expenses.

A 76 year old woman was admitted to a local hospital with a history of heart failure and heart disease. She was discharged with no in-home medical assistance or other needed services. After she was at home alone, a social worker from Jewish Family and Childrens Service visisted her and found her very ill. It turned out she had a second heart attack. She became so weak, she had to be put in a nursing home.

A widowed elderly gentleman, aged 64, has had multiple strokes. He has been attending Eating Together in Baltimore sites for regular meals and social contact. His lack of mobility has left him depressed and he has begun drinking again. Because of his alcoholism problem, he no longer attends ETIB. His nutrition status and personal needs are no longer being met. He is on a waiting list for mental health and chore services.

Cases such as these tend to involve not only medical needs, but social needs as well. Caseworkers spend numerous hours looking for appropriate services and funding sources in a disjointed, underfunded system. In many of these types of situations, individuals may eventually be institutionalized, when they might have been cared for in the community because not enough services could be found or purchased for them.

Comprehensive services must be provided to insure the health and well being of the elderly in the community. A package of services with a good case management system to coordinate all of them is essential. Services should include: nurse assessments; home health services including skilled nursing and personal care services; chore, homemaker services; mental health services; transportation; housing referral; educational services; and nutrition services.

Efforts should be made to keep the individual in the community as long as possible. However, in planning for care for the elderly, we must also think in terms of a continum of care. There will always be a need for some institutional care. Access to good hospital care will be important as well.

At the other end of the spectrum, good preventive care is essential. Not enough attention is paid to preventive services which may save money in the long run. The list of uncovered benefits under Medicare is a good indication that we are not meeting preventive medicine needs: routine physical examinations; dental care; eye exam and eyeglasses; routine foot care; immunizations; hearing aids; drugs and medicines; and outpatient alcohol detoxification.

When financial resources of the elderly dwindle, routine doctor visits and other basic needs are often eliminated from the budget. Increased premiums and deductibles under Medicare provide further incentive to go without needed medical treatment until the crisis arises. Another sad phenomenon is the migration of physicians from poorer urban areas. They would sooner move to outlying, wealthier suburbs where they can be more assured of getting full reimbursement.

HMOs designed for care for the elderly may be one solution, but these projects are still financially risky, and may not always be able to provide the complete spectrum of essential preventive and treatment services.

In summary, it would be remiss for you at the Federal level to assume that states and cities will solve the problems of care for the elderly. Your input will continue to be essential. We will need increasing support as the population grows older.

Actions of the past few years are not promising. I am very concerned about cutbacks coming at a time when we should be looking at increasing resources for this particular segment of the population. The gaps you are creating in the system in both medical services and social services cannot be magically filled by state and local governments. It appears that not much forethought has been given to the possible negative outcomes of Federal policy changes.

Shorter hospital stays are causing a myriad of difficulties and may not be as cost-effective as intially thought. They are transferring costs from hospital care to nursing home facilities and home care. There is also some information that readmissions are increasing, and cancelling the cost savings initially intended

Other Medicare and Medicaid cuts are resulting in further transfer of costs from the Federal level to the state and local level as well as the pockets of the elderly. Social program cuts are adding significantly to the local burden.

If we are to be forward looking and humane, we must find cost-effective, creative solutions to the growing demand for services. Certainly, comprehensive services at the community level are desirable. We should keep in mind that a continuum of care will be essential, including at one end preventive care services, and at the other, institutional services.

Work with us. Do not leave us stranded. Financially strapped localities cannot handle the burden. If you don't plan with us and support us, the real tragedy will be the people who do not have access to services they require.

The CHAIRMAN. Thank you for a very excellent testimony. It is usually under our procedure that we ask questions of the witness. We are not going to ask questions at this time due to the fact that the Governor is here, and we would like to hear from him. And then we would like to ask questions of both of you. Will you please remain. Thank you very much.

Mr. Skelton?

Mr. SKELTON. May I ask unanimous consent that my statement be included in the record after yours and Mr. Regula's?

The CHAIRMAN. Without objection.

Would anybody else like to make a similar request?

Ms. OAKAR. Mr. Chairman, I would. Thank you.

The CHAIRMAN. All right, without objection.

All members, then, can submit their opening statement to appear in the record immediately following that of Mr. Regula.

Governor, I would like to welcome you to the committee this morning. Congressman Pepper, who was here earlier, was going to introduce you. I am going to ask now that Congressman Mica make the introducion at this time.

Mr. MICA. Thank you, Mr. Chairman. I would just like to take a moment and say welcome to Gov. Bob Graham of the State of Florida for being here today, and we appreciate your taking time out of your busy schedule.

Florida, with the most rapidly growing senior citizen's population in the Nation is indeed a laboratory for the programs that will effect all of the Nation. Under our Governor's leadership, we have done a phenomenal job in breaking new ground and trying methods and new approaches. And while we are doing it, the Governor has done a tremendous job in saving money. I think he will point out to us some of the right ways to approach some very difficult problems, and some of the wrong ways that have been suggested.

And with that, I would like to welcome our Governor, Gov. Bob Graham from the State of Florida. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Governor, Senator Pepper, just before he left said that you and Mrs. Graham were the best friends that the elderly could possibly have in this Nation. I therefore, in that spirit, welcome you. Will you please proceed in any manner that you may desire?

STATEMENT OF HON. ROBERT GRAHAM, GOVERNOR, STATE OF FLORIDA

Governor **Graham**. Mr. Chairman, thank you very much. To my good friend, Congressman Mica, I appreciate those generous words, and also the words of friendship by Senator Pepper. There is no question as to who is the best friend of the older American in our country, Senator Pepper.

I would like to begin by expressing my appreciation for this committee's diligence on behalf of the needs of the older American. Since preparing my testimony, I have read news accounts concerning the administration's proposed cuts in a Medicare Program relating to home and community-based care. Without full details it is difficult to comment analytically. However, cuts in this program will tend to make it more difficult to implement long-range strategies for promoting good health and lowering health cost.

This appears to be a Federal policy which will show a short-term economic gain, but only at the cost of significant long-term damage and fiscal cost.

The State of Florida is grateful for the opportunity to present testimony concerning the issues of aging and health care costs, two of the areas in which our State has been listed as a megatrend State. Our State, like yours, Mr. Chairman, has set in motion trends which affect the rest of the world and will do so for years to come.

Florida today is America's No. 1 retirement State. Approximately one-fourth of all Americans who leave their home at the time of retirement move to Florida. In statistics released last week by the Bureau of Census, Florida heads the list of States with high populations of persons over the age of 65. As of July 1, 1984, Florida had 1,931,000 citizens over the age of 65, an increase of 243,000 since the 1980 census.

What have we learned about the aging population in Florida? First, we have learned that developing strategies for dealing with the issues related to aging is not solely the role of government. There is a role for the individual. There is a role for families, for communities, for society as a whole through government, private organizations, and business.

Second, we have learned that senior Floridians are getting older. The fastest growing segment of our aging population is composed of people who are over the age of 85. Third, we have learned the economic devastation which often accompanies long-term institutionalization. The University of Florida Center for Health Policy Review reported that 34 percent of all private pay patients in nursing homes in 1983 exhausted their entire financial resources within the first 4 months and resorted to medically indigent status.

These elements combine to squeeze older Americans and their families. As more and more Americans live longer, they run a greater and greater risk of needing long-term care. But the cost, human and fiscal, of that care continues to rise.

The result is that if we continue current attitudes in policies, there is likely to be a significant increase in the number of Americans who end their days on Medicaid in a nursing home after having exhausted all their resources. The good news is that it is both possible and desirable to postpone, even prevent, the need for institutional care for substantial numbers of senior Americans. Although Florida has the highest proportion of its citizens over the age of 65, in excess of 1 out of 6, Florida is 49th among the States in the number of nursing home beds per 1,000 persons over the age of 65.

We have a ratio of 23 beds per 1,000 of our population over the age of 65, as against the national average of 54 beds per 1,000 in the population over 65. One reason for that low number of nursing home beds in Florida, is Community Care for the Elderly. This program helps senior Floridians remain active and independent at home and in control of their own environment.

Medicaid funds only 8 percent of the cost of this program. State funding has increased by 338 percent since 1981. This year's legislature appropriated an additional $3.5 million, raising the total budget to $26 million. This is not enough. Today we are meeting 36 percent of the need for such services. Our goal is to fully meet the demand for services within the next decade. In addition, Florida has initiated other new programs without Federal assistance. One is the Florida Home Care for the Elderly Program. This program provides a direct subsidy to family care givers who maintain a frail elderly person in their own home.

This program provides an average subsidy of $122 a month to stabilize the home environment of a person who otherwise would be eligible for a Medicaid supported nursing home—at a savings to the taxpayer of $10,000 per patient per year. We are doing this because it is the right thing to do, and also because it is the prudent thing to do from a cost standpoint. Community care provides an alternative to a nursing home at a fraction of the cost with better quality of life.

Consider some of the evidence. In Panama City in the district of Congressman Earl Hutto, the Bay County Council on Aging provides 6 months of services such as Meals on Wheels, the Senior Center, adult day care and transportation at the same cost at 10 days in a nursing home. And that equation—6 months of services, equals the cost of 10 days in a nursing home—does not compute the incalculable human benefits to the senior Floridians who avoid the tragedy of premature institutionalization.

Consider a few of the lives that community care has enriched: Community Care provides a 74-year-old Linda Robinson of Hialeah in the district of Congressman Bill Lehman with help to shop, clean her home, do her laundry—and to cope with the recent death of her husband. Community Care means Meals on Wheels to Maria Monzona of Little Havanna area in Miami in the district represented by Congressman Claude Pepper. She is 95 years old, happy to be in her three-bedroom apartment in a neighborhood and cultural environment of her own choosing. And to Mr. and Mrs. David Traub of Pompano Beach in Congressman Clay Shaw's district, Community Care means continuing to live together at home despite Mr. Traub's growing infirmities.

For 4 hours each week, Mrs. Traub, who is 80, is relieved of her responsibility of caring for her 87-year-old bedridden husband. These 4 hours without worry are what Community Care means to Mrs. Traub. To her husband it means remaining in comfortable, familiar surroundings—and retaining control over his own life. These human examples have taught us in Florida that the gatekeepers in our health care system should inform themselves of alternatives to nursing home care and utilize in every case the option which is least confining and therefore also probably the least costly.

Federal policy which runs counter to this desirable outcome ought to be reviewed and altered. We are grateful for the opportunity to participate in that review.

The gatekeepers for Medicare, Medicaid, and other forms of health insurance should be encouraged and provided the option of placement of older Americans in alternatives to nursing homes. Once placed in a nursing home, there is a tendency to institutionalization which resists return to a less custodial setting.

The experience in Florida is that two-thirds of those who enter nursing homes as private pay patients will soon exhaust their resources and ultimately be supported by Medicaid as a medically indigent.

Another key to broadening the system to prevent the spending-down of life savings of millions of middle-class Americans is the Medicaid home and community-based services waiver.

This program permits the Department of Health and Human Services to waive the restrictions on the use of Medicaid funds, allowing us to use these funds to help people avoid, institutionalization. By waiving the restrictions, we can divert funds from high cost services in hospitals and nursing homes into an effort to provide the types of care I have just described—much less costly care at home which can prevent the isolation and high cost of a nursing home.

We have just completed our first 3-year cycle under a Medicaid home and community-based services waiver. Florida recently was granted an extension of this waiver for our elderly clients in the program.

Based on these experiences we can offer five specific recommendations. First, eligibility criteria for participants must include not only those on the verge of nursing home care, but also those whose infirmity requires stabilization for continued home care. Prevention, early intervention, and stabilization are the goals we should establish and achieve—not limit ourselves to crisis management. The immediate prospect of nursing home placement should not be the overwhelming criterion for acceptance into the home and community care programs.

Second, alter the fee structure for middle-income participants to encourage rather than discourage, participation in home and community-based services. If you earn $670 a month, you pay $345 a month for services. A fee this high discourages many from seeking the care that we are seeking to provide.

A third recommendation is to rescind regulations linking the number of people eligible to participate to the availability of vacant nursing home beds. Last year, average Medicaid nursing home care cost $12,000 per patient. But the cost per participant in home and community-based services was only $3,500. When you do the mathematics of the cost of this policy, you discover that for the 8,000 participants in Florida's program, Medicaid enjoys an annual cost reduction of $36 million.

We ask, therefore, Mr. Chairman, that this unrealistic policy of tying the number of eligible participants to the number of vacant nursing home beds be rescinded—so that we can reach our goal to contain the cost of care through the development of community alternatives.

Our fourth recommendation is to build into this program a growth factor. Florida is among America's fastest growing States with an average annual increase of population of 300,000. Over 40 percent of that increase is represented by Americans 55 years of age or older. Over 20 percent is represented by persons over the age of 65. Should those citizens from Ohio, Michigan, Pennsylvania, or New York be penalized by the denial of access to this community-based program merely because they decided to retire to Florida?

Our final recommendation is to encourage this committee and the Congress to consider Senate bill 1277. This legislation, sponsored principally by Senator Bradley of New Jersey and Florida's senior Senator, Lawton Chiles, does two things: It makes home and community-based services a standard option each State's Medicaid plan, and it attacks the Medicaid bias in a fee structure, lowering it by $150 per month.

Let me reiterate my thanks to you, Mr. Chairman, for the opportunity to share the experience of America's No. 1 retirement State with this committee and to thank you and the members of this committee for sharing the concern we feel for our senior Americans.

[The prepared statement of Governor Graham follows:]

PREPARED STATEMENT OF HON. BOB GRAHAM, GOVERNOR, THE STATE OF FLORIDA

Good morning: Let me begin by commending the members of this committee for your diligence in meeting the needs of America's aging population.

You are recognizing that we are all aging, regardless of what age group into which we may fall today. Every one of us has the potential to be affected by the issues of Social Security, long-term health care, and the rising cost of both.

The state of Florida is grateful for the opportunity to present testimony concerning the issues of aging and health care costs, two of the areas in which Florida is a megatrend state.

Ours is a state which, like California, sets in motion trends which affect the rest of the world in the years to come.

Florida today is America's number-one retirement state. Approximately one fourth of all Americans who move from their home states after the age of 60 move to Florida.

In statistics released last week by the Bureau of the Census, Florida heads the list of states with high populations of elderly citizens. As of July 1, 1984, Florida had 1,931,000, an increase of 243,000.

By the year 1990, one Floridian in five will be age 65 or older.

That over-65 segment of Florida's population is growing nearly twice as fast as our population as a whole.

Florida is a national laboratory in this critical area of study and action. What we do in Florida today will influence the direction of America in the 1990s and beyond.

What have we learned about the aging population in Florida?

First, we have learned that developing strategies for dealing with the issues related to aging is not solely the role of government. There is a role for the individual, for our families, our communities and society as a whole, through government, private organizations and business.

Our destination is the goal of encouraging people to stay healthy, to promote wellness and prevent illness, to defer long-term care or prevent it all together.

Second, we have learned that Senior Floridians are getting older. The fastest-growing segment of our aging population is composed of those age 85 and above.

Because the incidence of illness requiring nursing-home care is associated with advanced age, such an increase in the ranks of those over age 85 indicates that a growing number of Floridians will require long-term care, raising the issue of how the bill for such care will be paid.

Today that cost is borne alternatively by society or the families of the elderly involved.

Third, we have learned, unhappily, that the costs of long-term care are continuing to rise. According to Dr. Elain Brody, a nationally recognized expert with the Philadelphia Geriatric Center, families today provide for 80 per cent of the care required by the elderly in America. But when nursing home care is required, at a cost of from $15,000 to $50,000 a year, the impact is devastating on almost any family.

The University of Florida Center for Health Policy Review reported that 34 per cent of all the private-pay patients in nursing homes in 1983 exhausted their entire financial resources within the first four months and resorted to Medicaid.

These elements combine to squeeze older Americans and their families: As more and more Americans live longer, they run a greater and greater risk of needing long-term care. But the cost of that care continues to rise.

Based on information from the University of South Florida Suncoast Gerontology Center in Tampa we can project that of all the individuals who enter a nursing home as private-pay patients, two-thirds will ultimately find themselves on the Medicaid rolls after spending their life savings on care.

The result is that, unless society intervenes, there is likely to be a significant increase in the number of Americans who end their days on Medicaid in a nursing home, having exhausted all their resources, in a medically indigent position.

What have these facts taught us in Florida?

The first lesson we can draw is that it is both possible and desirable to postpone and even prevent custodial care.

In Florida we have established a program called Community Care for the Elderly, which helps Senior Floridians remain active and independent, at home and in control of their own environment.

Medicaid funds only eight per cent of this program in Florida. State funding has increased, however, by 338 per cent since 1981. This year's Legislature appropriated an increase of $3.5 million, raising the total budget to $26 million—but it is not enough. We are meeting only 36 per cent of the demand for such services.

In addition, Florida has initiated new programs without federal assistance. One is the Florida Home Care for the Elderly Program. This program provides a direct subsidy to family care givers who maintain a frail elderly person in their own home.

This program provides an average subsidy of $122 a month to stabilize the home environment of a person who otherwise would be eligible for a Medicaid-supported nursing home—at a savings to the taxpayer of $10,000 per patient per year.

In part because of these programs, and in part because of such factors as climate and overall good health, Florida has America's second lowest ratio of nursing home beds to our elderly population—only 23 beds for each 1,000 citizens age 65 or older.

We are doing this because it's the right thing to do—and also because it's a prudent thing to do, from a cost standpoint.

Community Care provides an alternative to a nursing home at a fraction of the cost, with vastly better quality of life.

Consider some of the evidence:

In Panama City, in the district of Congressman Earl Hutto, the Bay County Council on Aging provides six months of services such as Meals on Wheels, the Senior Center, adult day care, and transportation at the same cost as ten days in a nursing home.

And that equation—six months of services equals the cost of ten days in a nursing home—does not compute the incalculable human benefits to the senior Floridians who avoid the tragedy of premature institutionalization. Consider a few of the lives Community Care has enriched:

In Sarasota, in Congressman Connie Mack's district, 80-year-old Nellie Thomas was living in a deteriorating rental apartment on the outskirts of town last yar. Her general weakness made it virtually impossible for her to take care of her home, even with help.

Fortunately, through the Community Care program, Mrs. Thomas was assisted in moving in with a neighbor whose husband had died and left her with a three-bedroom house.

Together, these two women are caring for each other with help from the Community Care for the Elderly program. Both are in better spirits and better health.

In Congressman Bill Young's district, in the Pinellas County community of Largo, Mr. Ueckerman is a victim of Alzheimer's Disease. His condition was diagnosed in 1970 and has steadily progressed over the past 15 years, with frequent crises and continuous need for assistance.

His wife has written to several state legislators to thank them for the Community Care for the Elderly program. She says the initials of that program, CCE, really stand for "conscientious, caring efforts."

Community care provides 74-year-old Linda Robinson of Hialeah, in the district of Congressman Bill Lehman, with help to shop, clean her home, do her laundry—and to cope with the recent death of her husband.

Community care means Meals on Wheels to Maria Manzano of the Little Havana area in Miami, in the district represented by Congressman Claude Pepper. She is 95 yeas old and happy to be in her three-room apartment in a neighborhood and cultural environment of her own choosing.

And to Mr. and Mrs. David Traub of Pompano Beach, in Congressman Clay Shaw's district, Community Care means continuing to live together at home despite Mr. Traub's growing infirmities.

For four hours each week, Mrs. Traub, who is 80, is relieved of her responsibilities of caring for her 87-year-old bedridden husband. These four hours without worry are what Community Care means to Mrs. Traub. To her husband, it means remaining in comfortable, familiar surroundings—and retaining control over his own life.

These data, and more, have taught us in Florida a second lesson:

That lesson is that the "gate-keepers" in our health-care system should inform themselves of alternatives to nursing-home care and utilize in every case the option which is least confining, and therefore also probably the least costly.

A third lesson we have learned is that federal policy which runs contrary to this desirable outcome ought to be reviewed and altered. We are grateful for the opportunity to participate in that review.

A key to broadening the system to prevent the spending-down of the life-savings of millions of middle-class Americans is the Medicaid Home and Community Based Services Waivers.

This program permits the Department of Health and Human Services to waive the restrictions on the use of Medicaid funds, allowing us to use these funds to help people avoid institutionalization.

By waiving the restrictions, we can divert funds from high-cost services in hospitals and nursing homes into an effort to provide the types of care I've just described—much less costly care at home which can prevent the isolation and high cost of a nursing home.

We have just completed our first three-year cycle under a Medicaid Home and Community Based Services Waiver. Florida recently was granted an extension of this Waiver for our elderly clients in the program.

In our first three years under this program, we have experienced restrictive eligibility policies, regulations which preserve the institutional bias of the Medicaid program, arbitrary limitations on the number of Senior Floridians who may participate regardless of eligibility, regulatory provisions which prevent growing states such as ours to keep up with population increases, and an elaborate and prolonged review of our extension request.

Based on these experiences, we can offer five specific recommendations:

First, eligibility criteria for participants must include not only those on the verge of nursing-home care, but also those whose infirmity requires stabilization for continued home care.

Only clients in immediate danger of placement in a nursing home meet the level-of-care critical for the Community Based Services waiver. If our common goal is to maintain our elderly population in their homes, this is counter-productive.

We are ignoring problems at the stage where they are most likely to be solved quickly and relatively inexpensively, and deliberately allowing the to reach the crisis point—a point at which it is often too late to prevent institutionalization.

Prevention, early intervention and stabilization are the goals we should establish and achieve—not crisis management. The immediate prospect of nursing home placement should not be the overwhelming criterion for acceptance into the home and community care program.

Second, alter the free structure for middle-income participants to encourage, rather than discourage, participation in Home and Community Based Services.

The waiver continues to institutional bias of the general Medicaid program. This bias is evident in the eligibility criteria for clients whose income falls between two point on the scale—the Social Security Income program limit of $325 a month, and the Institutional Care Program limit of $842 a month.

For those within that range, a fee for services is required. This fee is determined by subtracting the "protected income" level of $325 a month, and applying the fee to what remains.

If you earn $670 a month, you pay $345 a month for services. A fee this high discourages many from seeking the care which we are seeking to provide.

The goal of eliminating the institutional bias of the Medicaid program is not being realized because the regulations are excessively restrictive. We recommend reducing those fees significantly to encourage more people to participate.

A third recommendation is to rescind regulations linking the number of people eligible to participate to the availability of vacant nursing home beds.

As I mentioned earlier, Florida has America's second-lowest number of nursing-home beds per 1,000 people over the age of 65.

This policy rewards the success of our efforts to keep people out of the confinement of nursing homes with this punitive outcome:

Because of the cap tied to nursing-home beds, we can serve only approximately 8,000 individuals. But there are thousands more elderly people who need the Home and Community Based Services program.

Last year, average Medicaid nursing home care cost $12,000 per patient. But the cost per participant in House and Community Based Services was only $3,500.

When you do the mathematics of the cost of this policy, you discover that for the 8,000 participants in Florida's program, Medicaid enjoys an annual cost reduction of $36 million.

We ask, therefore, Mr. Chairman, that this unrealistic policy be rescinded—so that we can reach our goal to contain the cost of care through the development of community alternatives.

Our fourth recommendation is to build into this program a growth factor.

Florida is among America's fastest-growing states, and our elderly population segment is growing as rapidly as any. Last fall we moved from seventh to sixth on the list of America's 10 most populous states, and by the year 1988, it is projected that we will be fourth.

Millions of our citizens come from other states, Mr. Chairman, just as do the citizens of your own home state of California.

Should those citizens from Ohio, Michigan, Pennsylvania or New York be penalized by the denial of access to this program, merely because they have decided to retire to Florida?

This growth cap will deny needed care to citizens now living in the states represented by the members of this committee. Surely, your constituents deserve better.

Here is a program which works, which restores dignity to elderly Americans, and which is cost-effective.

Why should we limit the growth of a program which tends to curtail the cost of long-term care, offers cost savings every year, enriches the quality of life of the people it serves, and maintains infirm elderly Americans in familiar surroundings, in their own homes, with their own families?

Why limit the growth of a program that does all that?

Our final recommendation is to encourage this committee and the entire Congress to consider supporting Senate Bill 1277.

This legislation, sponsored principally by Senator Bradley of New Jersey and Florida's Senior Senator, Lawton Chiles, does two things:

It makes Home and Community Based Services a standard option in each state's Medicaid plan, and it attacks the Medicaid bias in the free structure.

The first aspect would make this outstanding, cost-effective program standard, not something accompanied by the onerous regulatory processes through which state must now go.

The second element of this bill reduces the fees charged to middle-income participants by $150 a month, by raising the "protected income ceiling" from $325 a month to $475 a month. This will bring the benefits of this program to elderly citizens whose only choice today is to wait until their health deteriorates to the point at which they require institutional care.

Let me reiterate my thanks to you, Mr. Chairman, for the opportunity to share the experience of America's number-one retirement state with this committee, and to thank you and the members of this committee for sharing the concern we feel for our elders.

The Senior Floridians with whom I talk want to live out their lives in their own homes, with the same dignity, independence and freedom of choice that we all cherish at every age.

The regulatory structure of the Medicaid program today interferes with that fundamental of American freedom.

Thank you for responding to the need in the lives of older Americans in Florida—millions of them originally from other states. And thank you for helping them to lead independent lives, by restoring this vital link in the long-term care system.

The **Chairman**. Governor, I would like to thank you for your testimony this morning. From your comments, I can definitely say that the problems that you find in Florida, you seem to find also in Baltimore and in other cities throughout the United States. We seem to have somewhat of a unique problem in Florida, due to the fact that it is a retirement community.

It is my understanding, however, that if one compares that with other retirement communities that you will find that those are also comparable. But we are told by the new regulations under Medicaid's home and community-based program will discourage States from participating. Do you agree with that?

Governor **Graham**. Mr. Chairman, I have listed the areas in which we have found concerns, such as the linkage of the number of eligible participants to the number of vacant nursing home beds, the failure to maintain currency in terms of population growth with eligibility, and the fee structure which discourages many middle-income elderly from taking advantage of the community-based services.

Our belief is, and the evidence of our State supports this, that effective community-based programs which are targeted at early intervention and the maintenance of wellness, at the prevention of health care crises, is both humane and cost effective. I indicated earlier that while we have the highest proportion of our population over the age of 65, we are 49th among the 50 States in the proportion of nursing home beds.

If we had as many nursing home beds in Florida as the national average, with our large population we would have enormous additional economic costs, costs to the individual and costs to government at the Federal and State level.

We believe that regulations of the administering agency which have the tendency to restrict participation in alternative community-based programs are not only adverse to the interest of the older American, but are adverse to the interest of all American taxpayers.

The **Chairman**. The situation as we see it, and as we have been constantly told hearing after hearing, is that hospitals are pressured to reduce costs so what they do is to discharge patients early. These people, much of the time, are still ill when they go home, but they are denied nursing home and health services under Medicare. And many of them are not poor enough to qualify under Medicaid. What happens to them?

For example, you told the committee that 34 percent of the senior citizens in Florida exhausted their means within 4 months. What happens to these people?

Governor **Graham**. They then become medically indigent and eligible for Medicaid, and at that point they become a responsibility of Federal and State government under the Medicaid Program. You also have an individual who has spent a substantial number of weeks in an institutional setting. It is very difficult to then return that individual to a less custodial environment.

We think that it is critical that there be a close interface between Medicare and Medicaid in terms of that initial admission to an institutional setting, because once that is made, there is great likelihood that that individual will continue to stay in that setting, and an even greater likelihood that while he is there, he will exhaust his financial resources. It then becomes a virtual certainty that he will become a financial responsibility of the State and Federal Government for the balance of his life.

The CHAIRMAN. Thank you, Governor. I have some questions I want to ask the mayor along the same lines, but we will wait until after you have finished your testimony. Mr. Regula.

Mr. REGULA. Thank you, Mr. Chairman.

Governor, have you taken any steps to consolidate the health care delivery systems for long-term care in the State of Florida in an effort to cut administrative costs while at the same time improving services. Most of the States have a proliferation of agencies dealing with problems, and I think there is a lot of duplication of administrative cost. I would be interested in what you have done, if anything, in Florida to address that problem.

Governor GRAHAM. Our basic social health service agency, the Department of Health and Rehabilitative Services, is an integrated agency, which has responsibility for all of the programs that relate to elderly care, either community-based or custodial. Through that system we have established a gatekeeper function in which we try to place the elderly person in the least restricted environment appropriate to his needs—starting from community-based programs, then to various forms of nonmedical custodial care, various forms of elderly housing programs, and, only as it is necessary for medical reasons, placing individuals in nursing homes.

Mr. REGULA. Governor, do you find this system as working well and also do you find that any of the Federal regulations inhibit your ability to consolidate these services for the elderly?

Governor GRAHAM. The evidence of the low ratio of nursing homes to population is evidence of the effectiveness of the program of trying to restrict the use of nursing homes, the most expensive long-term health care option, to the maximum extent possible. I indicated in my remarks some of the areas in which we believe that Federal changes in law or regulation would be beneficial to us. It would be beneficial to us if under the Medicare Program there were a greater orientation to use less restrictive care settings than nursing homes because of this domino effect—a person who enters under one program has a high probability of ending up as a Medicaid client.

Second, it would be helpful if under Medicare and Medicaid waivers there was greater recognition of the positive benefits which could be gained by funding noninstitutional, nonhospital, nonnursing home programs to assist in maintaining a stabilized elderly individual without waiting until he got into a crisis situation.

The chart illustrates the disparity between the proportion of Floridians over the age of 65, 17.6 percent of total population—as against the nation's 11.4 percent over 65—while Florida has a ratio of 23 nursing home beds per 1,000 of persons over 65—as against the U.S. average of 54 per 1,000.

Mr. REGULA. You think this would result because those who tend to go to Florida would be economically in a better condition and also more mobile and would they tend to go back to their home once they reach a physical condition needing a nursing care, or is that factor in your judgment.

Governor **Graham**. Those are factors. I think it is accurate that of those Americans who move at the time of retirement, that group probably represents a higher level of good health than those who elect to stay in their original community. It is also true that there is some bilateral movement of the elderly returning to their homes at time of crisis. But we are also experiencing a tremendous elongation of the age of our older Floridian.

In the 1980 census, those persons in Florida over the age of 75 grew at a rate twice as great as the base population in Florida. The base population grew at 43 percent. Those over 75 grew at 86 percent, and as the statistics indicate, since the 1980 census those over 85 are now outpacing those over 75 in terms of their rate of growth. So, when you put all those factors together, I don't think that the Florida elderly population is an inappropriate one from which to draw some national conclusions.

The **Chairman**. The gentleman's time has expired. Mr. Erdreich.

Mr. **Erdreich**. Thank you, Mr. Chairman.

Governor, thank you for coming and appearing before us. I was interested in your comments about your State's Medicaid waiver for home services. I had sought to get such a waiver in Alabama. We got it, but from reading your testimony, it looks like the built in bias toward institutional care remains in that Medicaid Program.

I was curious—one of your recommendations on page 6 of your testimony says that you would recommend rescinding regulations that link the number of people eligible to participate to the availability of vacant nursing home beds. Explain how that works right now.

Governor **Graham**. Under the current regulations, we are restricted to 8,000 persons participating in this waiver program because of a formula which says the number that can participate has to be in relationship to the number of vacant nursing home beds. I do not know what that formula is. I know we have approximately 5,000 to 6,000 vacant nursing home beds in Florida as of today.

It seems to me that those two considerations, vacant nursing home beds and number of persons who can appropriately be served in a less constrained environment, are discrete considerations. The goal ought to be to attempt to have an effective program that maintains and stabilizes the older citizen rather than wait until he is on the verge of having to go into a nursing home before providing him with some alternative services.

Mr. **Erdreich**. Thank you. I appreciate that.

Thank you, Mr. Chairman.

The **Chairman**. Mrs. Schneider.

Mrs. **Schneider**. Thank you, Mr. Chairman.

Governor Graham, I wonder if you could address the question—we have mostly been focusing on health care either instutionalized in the hospitals or in nursing homes. But I would like to focus a little bit on home health care. And I just happened to have met with a number of constituents yesterday who work at a hospital who are concerned about the early dismissal of patients who are often times terminally ill, and yet are sent home. And then the problem, as they describe it, seems to be that the intervenors, in this particular case, Blue Cross/Blue Shield, determines that because this person is terminally ill and because they do not need to have one form of either physical therapy or one form of assistance or another, that they are no longer eligible for insurance coverage.

There seems to be a grassroots effort afoot to have the intervenors become more responsible. What has been your experience in this particular area of the problem?

Governor **Graham**. Our experience has been that there is a tremendous bias toward institutional care as opposed to less restrictive alternatives; second, that that bias is a strong component of Medicare. Medicare was originally conceived of as a crisis intervention program and has not developed an extended care component. That goes beyond the remarks that I made today, but it might be an issue appropriate for this committee to consider. For examples, what should be the role of a long-term care insurance program as distinct from a medically indigent program——

Mrs. **Schneider**. Right.

Governor **Graham**. In the area of extended health care—in the context of a nation with an increasingly greater life expectancy and a higher and higher percentage of our people reaching ages 85 and beyond—the likelihood of a need for a long-term care insurance program becomes very high.

In the private insurance industry there has been some increasing flexibility in terms of accepting alternatives to institutional care as being appropriate and compensable. We are working as an employer. The State of Florida is the largest single employer in our State to try to incorporate some of those principles in our insurance coverage for our citizens.

Mrs. **Schneider**. But one of the alternatives, particularly in the area of the terminally ill is the hospice care alternative. And I wonder if you could just briefly incapsulate for us what has been your experience with the elderly using hospice as an alternative and the responsiveness or lack of responsiveness on the part of the private insurers.

Governor **Graham**. Our legislature passed a hospice statute approximately 5 years ago. It is still a relatively minor option of choice in terms of all older Floridians.

Mrs. **Schneider**. Why is that? Is that just because the supply is not there or——

Governor **Graham**. I think it is a combination of the newness of the program and the idea. There is a great psychological barrier to one's accepting the fact that death is near and there is a need to be in a setting which transitions from life to death. That is not an easy decision for any human being to make. But I think it is a humane alternative, and I would anticipate that increasing numbers of people will seek it out.

It falls into the general strategy that we should not think of the elderly as being a homogenized segment of our population. The elderly have the same range of diversity of interests, backgrounds, needs, personal desires as does any other group of Americans. And therefore to the extent that Government policy is relating to their need, they should have diversity, options, choice, and within that a bias toward independence, minimization of institutional care, prevention, and good health.

Mrs. **Schneider**. Terrific idealism. Let's just hope we can all implement it. Thank you.

Governor **Graham**. I think those two charts are some evidence that it is not a dream; that it can be made reality.

Mrs. **Schneider**. Thank you very much. Thank you, Mr. Chairman.

The **Chairman**. Ms. Oakar.

Ms. **Oakar**. Thank you, Mr. Chairman.

Governor, I was very impressed with your testimony. It is a pleasure to see you here. And I was very impressed with Mayor Schaefer's testimony previous to your speaking, as well.

You mentioned in your previous comments to the Congresswoman that you seemed to think that there is a bias toward institutional care which, of course, is much more expensive. And you said earlier that we need to maintain and sustain older people, and that's what Mayor Schaefer said, too. Once people get out of the hospitals you can't just leave them, you know, without any kind of care.

I am wondering if you are aware of the fact that the administration has just proposed to change the regulations related to home health care, which would make it more difficult for providers to get reimbursed for home health care. It is about—I am trying to be generous, but it is about the most ignorant idea I have ever heard of because home health care is good prevention, and it promotes cost containment, and, psychologically, it is better to serve people in their own homes.

So I am wondering, you certainly serve a sizeable number of the elderly. What impact would not having a valuable home health care services have on your constituents? Should we be doing more in this area in terms of alternatives or less, or is the administration on the right track in saying that cutting home care really saves money?

Governor **Graham**. Madam Congresswoman, when you ask the question—does it save money—it depends upon what balance sheet you are looking at. If you are looking at the next quarter, the answer is, yes, it will save money in the next 90 days. If you are looking at the next 5 years, it is a tremendously counterproductive and expensive decision, because of the effect of that is to drive more people into more expensive forms of health care.

And, then, we must consider the human tragedy that will be occasioned by denying people the opportunity to do what they want to do—which is continue to live in their home—and instead force them prematurely into an institutional setting. There was an interesting survey published last week in the New England Journal of Medicine on the DRG Program, the diagnostic-related groups, indicating that there were great differences in the condition of patients within a particular category. Under the current system, and without regard to that difference, the same amount of reimbursement is available to the hospital provider for all persons.

To me, that underscores the importance of having a post-hospital support system. That is, objectives of the DRG system is to encourage hospitals to shorten the period of hospitalization. That would indicate that people are going to be released when they still are in need of some medical support. The Home Care Program is the primary means of that support for those individuals who look to Medicare for their financial payments of health-related expenses.

If we cut that off, we are hitting them twice; once through a DRG system which truncates their care in hospitals, and then by restrictions on home health care which will dilute their posthospitalization support system.

Ms. Oakar. Governor, doesn't home health care also prevent people from going into or needing more expensive care. You know, we used to have a regulation—and in fairness, it was during the Carter administration—that said that you had to go into the hospital for 3 days in order to be eligible for home health care. Well, through legislation we eliminated that because that didn't make sense.

I just think that so many people are so afraid to look at alternatives which in the long run, as you very wisely pointed out, would save so much money and deal with the issue. And I just take such exception to what the administration is doing with respect to this renewed assault on home health care. We know that the heavy duty lobbyist are not in the home health care industry, you know, because it is not an expensive kind of care.

I want to commend the chairman for his news release on that issue, because it is right on target. I really want to thank you and the mayor for being here. Your testimony was eloquent, and I feel very fortunate to have listened to you today.

The Chairman. Thank you, Ms. Oakar.

Mrs. Bentley.

Mrs. Bentley. Thank you, Mr. Chairman.

Mr. Governor, I was interested in your statement, too, as well as, of course, from the mayor of whom we are all so very, very proud in the Baltimore area. I'll get into that later.

As the Governor of the third largest State and as we know you have not as many problems perhaps, but plenty of them. If you were able to get one thing done in the improvement of health care for the senior, let's say if you had one wish, what would you say is the most important thing to be done immediately by this Congress?

Governor Graham. The most important objective is to maintain the health of the older citizen. To accomplish that objective, I would encourage the Congress to look to means by which it could redeploy Federal health care resources into programs that had demonstrated their ability to maintain a level of good health among our older citizens—programs, such as effective social service programs, such as the Meals on Wheels Program. Nutrition is a major health problem for many of our elderly citizens.

Access to regular health checkups and screening so that diseases can be identified at an early stage and can be dealt with in the least harmful way to the patient and least expensive way to the patient and Government—those would be tactics within that goal of maintenance of health. I am afraid that the current system started with a bias when it was established in the mid 1960's which continues today, and that is crisis intervention. When you get sick enough to have to go into a hospital, then the calvary with aid comes across the mountain.

The goal ought to be to substitute for the calvary appropriate nursing and social programs that will prevent the necessity of placing that person in the hospital.

Mrs. **Bentley**. I think that is very worthwhile for us to be thinking about, Mr. Chairman. Thank you very much, Mr. Governor.

The **Chairman**. Thank you, Mrs. Bentley.

Governor, I think we ran over our scheduled time, but the members do have some questions or words of wisdom or welcome. I am going to permit a continuation of the questioning period. I am going to ask each member to limit themselves to one good question.

I am going to ask your colleague, the gentleman from your own State, Mr. Mica, to ask that one important question at this time.

Mr. **Mica**. All right, I will try to be brief, Mr. Chairman. I would like to commend the Governor, again, for his insight and just point out to my colleagues what we have here today. Baltimore, they are having a problem with 13 percent over 65 in one city. Our city is 17 percent over the age of 65. My district is 34 percent over the age of 65.

In hearings like this in Florida, we had an individual sit before the microphone and say, "We in Florida have long since lost the fear of dying. We are afraid of living and getting sick and not being able to pay the bill." That is the new fear in seniors in this Nation.

Now, your study, Mr. Chairman, says that 60 percent of the nursing homes are getting increased patient load because the DRG's are squeezing them out very quickly. And with that, the State of Florida—and this will be the question, Governor—the State of Florida is picking up a greater burden because of over 40 percent more are being denied. The trend is obvious. The cuts are coming at the hospital level and the home health care level. How much longer can the State of Florida go to pick up the tab? Are we or can we pick up the full tab if we are required to do, and should States be required to do that?

Governor **Graham**. Well, I would like to answer the last question first, because I think a human society, any society which deserves to be called civilized, is going to provide appropriate care to those of its citizens in need. I believe that care for the elderly should be primarily a national responsibility, and I say that in the context of a governor who has supported increased State financial responsibility for programs such as education, law enforcement, and transportation.

Why do I say programs for the elderly should be a national responsibility? Because it is important to have a system that will allow people during their active years to be a major participant in supporting their deferred costs in their retirement years. We are a highly mobile population—approximately 20 to 30 percent of persons move to some other community at the time of retirement. If you do not have a national system, you cannot accomplish that objective of using the working years as a means of financing retirement years.

So my answer would be that health care for the elderly should be a Federal responsibility and that the Federal Government should resist programs which, under the guise of next quarter reduction of costs, end up adding to the total burden of all Americans.

The **Chairman**. Thank you, Governor.

The Chair recognizes Mr. McCain.

Mr. McCAIN. Thank you, Mr. Chairman.

I would like to pose a two-part question to you, Governor. I also come from a State which has a highly mobile population, and our numbers of elderly citizens dramatically change from one season to the other. How do your facilities accommodate the change in population from one season to the other?

Second of all, we are here today to take testimony from other witnesses concerning the DRG's, and as you have stated there are many people who are still ill and are being forced to leave hospitals. This, I am sure, has placed an additional burden on you.

The other part of this equation is that DRG's were enacted by Congress in order to help reduce the severe drain on our Medicare Trust Fund. We now have predictions that the Medicare Trust Fund has gone from a situation of imminent bankruptcy to solvency for a longer period of time. It seems to me that we are faced with a severe dilemma. If we do away with the DRG's completely, then we are back to where we were before, facing insolvency of the Medicare Trust Fund. At the same time we have inherited some very serious evils with this system.

So the second part of my question is do you have any proposals as to how we could take the DRG system and reform it so we are not subjecting our elderly to a situation where they are discharged early from a hospital?

Governor GRAHAM. Mr. Congressman. First, the statistic of 17.6 percent is the permanent population of Florida. During the wintertime particularly, the proportion of persons over the age of 65 would be higher than that, for there are thousands of individuals who spend a portion of the year in our State, but are not permanent residents. Yes, within such things as our Certificate of Need Program, we take into account the need to have a flexibile capacity to respond to those periods of the year when the demand will be higher than the base population would indicate is called for.

As to reforms in the DRG, first I support the basic philosophy of the DRG which is a prepayment philosophy. I do not think that we can continue a health care system that says: enter my door; I will then determine what services you need and how long you will receive then. When you leave the door I will send you a bill for the cost of those services that I rendered to you.

We have seen what that has done—the result was a health care system that was running ahead of the pace of inflation in the order of two or three or four times. So the basic principal of the DRG, I think, is a sound one. I would suggest two areas for congressional attention to reform. One we have already talked about, and that is the need to have effective posthospitalization care, recognizing that there are going to be people who will be dismissed from a hospital earlier than they would have been but for the DRG, and who are going to need a continuum of care in their home to bridge that period back to full health.

I believe, therefore, that the suggestions of reducing funding for home health care run counter to that objective.

Second, as we get more information about the DRG, probably it will become more sophisticated. For example, within the specific

400 or more cells of cost, there will be gradations provided based on a person's age and physical condition.

Obviously, a person who goes into the hospital at 75 for a hernia operation is a different medical case than a person who goes in for the same operation at 35. And a cost reimbursement system that does not recognize those differences is fundamentally flawed, but is redeemable by refinements that would build into a prepaid health care system the necessary nuances that would reflect categorization of age, level of health or absence of health at the time of entry into the hospital, and other considerations that would be appropriate.

Mr. McCAIN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Hughes.

Mr. HUGHES. Thank you, Mr. Chairman.

I just wanted to welcome Governor Graham to the hearing today and congratulate him on his testimony, particularly on Florida's Community Care Program. It sounds like a tremendous success. I have no questions.

Governor GRAHAM. I hope you will come to Florida, so we can have an opportunity to show it to you personally.

Mr. HUGHES. I look forward to doing that.

The CHAIRMAN. The Chair recognizes the gentlewoman from Kansas, Ms. Meyers.

Mrs. MEYERS. Thank you, Mr. Chairman. I do appreciate the testimony of Governor Graham and Mayor Schaefer. I have been very supportive. I was in my State legislature before I came here, and I have been very supportive of home and community-based care. And I am very pleased that we are having this kind of testimony today.

And in spite of the somewhat partisan comments by some members of this committee, I really don't think this is a partisan issue. I think all of us are very concerned about home and community-based care for the elderly.

I would like to ask a couple of questions. One, as I recall, when I was working at the State level, the participants in home and community-based care had to be on the verge of going into a nursing home in order to be eligible to participate, and there had to be some significant savings. I believe it was at least 5 percent. In other words, it had to be cost effective. It had to be lesser in cost than nursing home care.

Now is that still essentially the formula? Is that the formula that you are working with?

Governor GRAHAM. Our State community care program requires an individual to be Medicaid eligible; that is, he would be eligible for Medicaid if he were to go into a nursing home. We do not require that he be one step away from a nursing home in order to begin to participate in the program. If a person can indicate his likelihood of avoidance or deferral of the time when he would require nursing home care would be enhanced through the types of services that I illustrated in these few examples, he would be eligible to do so.

We currently are serving approximately 30,000 plus senior Floridians with this program—which we estimate is a little better than one-third of the total need within our State. And our goal, as I indicated, over the next 10 years is to move to fill 100 percent of the need for services to those who are eligible financially and can benefit, based on their circumstances.

Mrs. MEYERS. Now, when you have an individual who is in their own home maybe receiving services from several different kinds of private providers, what kind of monitoring does your State social agency do to make sure that those services truly are being provided and that elderly person who might be very vulnerable and isolated is truly getting the kind of care that they need?

Governor GRAHAM. Within our State department of health and rehabilitative services, a program office of Aging and Adult Services. Case managers under that program office are responsible for each of the recipients of Community Care for the Elderly Program.

I have a program in which I take a different job once a month. And one of my jobs was to work as a case manager in that program. And I got a little firsthand experience with the degree of close contact and care of the elderly person. I was able to see that the services that they are supposed to receive are being provided, that they are quality services, and that work with the providers encourages them to meet the needs of the elderly. Most of the providers are nonprofit. Many of them are religiously associated organizations. There are also some proprietary groups, particularly in the area of home nursing care.

Mrs. MEYERS. Thank you very much, Governor.

The CHAIRMAN. Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. Governor, I appreciate your tolerance today. As somebody once said, the mind will absorb only what is able to endure, and you have been here quite a while.

I'll make this as brief as possible. I represent a district that has over 20 percent of its people over the age of 65. You mentioned the DRG's a moment ago. We have found them to be rather devastating to our State's small rural hospitals. With that type of a population, a certain percentage of them bring their medical problems to you in Florida in the winter and bring them back to us in the spring.

But from your viewpoint, with the DRG's, have you spotted any particular problems that you have had with them? And if so, how have you handled those problems? Maybe that will give us some insight into how we can help on our side.

Governor GRAHAM. Mr. Congressman, I want to be candid. I do not sit here as an expert on the DRG process. I am concerned with the lack of nuance that the system has; that is, it's the inability to take into account factors that are reasonably related to the cost of health care services such as the age of the individual and his physical condition at the time of the entry into the hospital.

I believe those are refinements which are well within the capacity of the Congress and the administering agency to incorporate into the system. As I indicated in response to an earlier question, I believe the basic philosophy of paying for health care services on a contractual basis in advance rather than on a fee for services after delivery is a sound one. And it is one that is being used in many other areas. The whole growth of the health maintenance organizations are built on the same prepaid health care principle.

So rather than consider discarding the program, I would suggest that it ought to be looked at with a scalpel for refinement.

Mr. LIGHTFOOT. May I follow up very quickly?

Basically I guess the point I was trying to get to is, we are finding that the DRG's are being detrimental to a lot of our small hospitals. Now, are you experiencing that same kind of thing? Is it impacting them in a negative kind of way? If so, are you as a State trying to do something about it?

Governor GRAHAM. I would say if I had to select a category of hospitals that seemed to have been most adversely affected, it is not the smaller hospitals, but, instead, the most sophisticated hospitals—particularly those that are associated with a medical school—where, typically, the most serious cases are admitted.

You have a combination of health care plus medical education, and in some cases even research, which are difficult to unbundle from an economic standpoint. And therefore they probably are the most adversely affected financially from the DRG system.

Mr. LIGHTFOOT. Thank you, Governor, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Boehlert.

Mr. BOEHLERT. Thank you, Mr. Chairman.

I guess I would like to start with a protest of sorts. When we have witnesses of the caliber of Governor Graham and Mayor Schaefer with their experience and insight, I would hope that we would have more time to have the benefit of your counsel.

What I would like to do instead of asking one good question is ask one good question with 22 parts, but I know that wouldn't be permitted. But I am intrigued, Governor, by your Florida Home Care for the Elderly Program which is fully funded at the State level, and it is for the frail elderly and the average subsidy is about $122 a month and you figure it saves you something in the magnitude of $10,000 per care in Medicaid costs.

And I assume that the State picks up 50 percent of Medicaid costs.

Governor GRAHAM. It is less than 50 percent at the present time.

Mr. BOEHLERT. But that is very cost-effective program, so to ask the broad question, tell us a little bit more about the specific program, because it seems, one, to meet the needs of the people we are so concerned about, and, two, it seems to be most cost-effective, and, three, it seems to be innovative.

Governor GRAHAM. This is a program which subsidizes a family with a medically eligible elderly relative to keep that indiviudal in their home. Typically if a family includes a Medicaid eligible older person, that the family is probably economically distressed out of economic necessity. Many of those families might be inclined to place their frail elderly grandmother or grandfather in a nursing home, and therefore, see that the elderly person is served in an institutional setting and be relieved of the economic cost to them.

That is what the current system almost forces many families to do. What this program does is provide an alternative. And it says we will pay you $122 a month if you will keep your grandmother or grandfather at home and do what that older person and the family really wants to do, which is to keep the family together.

Mr. **Boehlert**. You said that is an average, right? So I assume there is higher payments and lower payments.

Governor **Graham**. Yes. And it saves the Federal Government, which pays better than 50 percent, and the State government, which pays the balance of the cost, from placing that person in a nursing home at $1,000 a month.

Mr. **Boehlert**. Governor, may I for the record, Mr. Chairman, ask that you have your staff provide some more information on the specifics of that program for the committee because I think it is quite interesting.

Governor **Graham**. We shall do so.

The **Chairman**. Without objection, it will be ordered.

[The following material was subsequently received from Governor Graham:]

Home Care for the Elderly

The Florida Home Care for the Elderly program is administered by the Aging and Adult Services Program Office, Department of Health and Rehabilitative Services.

The 1977 Legislature enacted the Committee Substitute for Senate Bill 178 as 77-336, Laws of Florida, in recognition of those families and friends who continued the tradition of caring for their frail and impaired elderly members of the family in their own homes without regard to the financial cost burden or the physical and emotional demands placed on the families' time and energies. This law was codified as Sections 410.031-410.034, Florida Statutes, and promulgated as Chapter 10A-9, Florida Administrative Code.

With recent trends to focus on home and community-based service programs and to encourage the maximum utilization of informal service support networks in lieu of the higher costing formal care models, the Home Care for the Elderly program stands as a viable model for a cost-effective alternative, and is designed as an alternative to nursing home and institutional care utilizing the family and friends of the frail and impaired elderly as the informal service support network. The legislative intent of the program is to encourage the provision of care for the elderly (those age 65 or over) in a full-time, family-type living arrangement in a private home by a person or group of persons, whether relative or non-relative, on a nonprofit basis. Services include three basic subsidy elements: (a) Basic support and maintenance payment to cover the cost of housing, food, clothing and incidentals; (b) Payments for medical, pharmaceutical, and dental services not covered by insurance; and (c) Special supplements to provide for any service and specialized care required to maintain the health and well-being of the elderly person.

Eligibility for those 65 and over who are at risk of institutionalization is determined by Health and Rehabilitative Services service units. Financial eligibility criteria are the same criteria used to determine eligibility for assistance under Title XVI of the Social Security Act as existed on July 1, 1977, or as used to determine eligibility for nursing home care under Section 409.266, Florida Statutes.

The service unit care managers also provide direct services to the recipient and the service provider. This coordination between the informal service support network and the case manager, together with the payments made for basic subsidy, medical support, and special supplements, combines to provide a model of care and services comparable to the care and services provided by the nursing home and institutional care models.

The **Chairman**. Governor, it is my understanding that Mayor Schaefer has to get away in about 5 minutes. But he is not going to get away until we ask him at least one question. I would like to have him come forward and sit next to you, because I think this question may need your assistance.

Mayor Schaefer, you told the committee——

Mayor **Schaefer**. Mr. Chairman, before you ask the question, may I just say one word?

The **Chairman**. Yes, sir. Will you proceed?

Mayor SCHAEFER. I am very impressed with the Governor, and I have learned a tremendous amount. Some of his ideas are innovative. I am very glad that I came. I appreciate the questions. A Governor who leaves the office and goes into a nursing home and works is my kind of man. And I just want to commend him, if I am not violating protocol by doing that.

The CHAIRMAN. Well, Mayor Schaefer, you are a mayor from another State, from the State of Maryland. And to hear that comment made by you, I think it is a real tribute to the Governor from the State of Florida.

Now, Senator Pepper told me that both he and Mrs. Graham were true friends of the elderly, and you have now confirmed that. But the one question, mayor, you said that 40 percent of Maryland's poor live in Baltimore. You also pointed out very effectively that hospitals are pressured to reduce cost and that they discharge early and that in many instances these people are still ill.

You went on to say that they are denied nursing homes and health care services under Medicare, which is not only in Maryland, but all over the country. And then I think you made the point that in most instances these people are not poor enough for Medicaid.

I asked the Governor a question with regard to those that come under Medicaid. He said, "well, then the State takes care of them". There are various States that find a person to be eligible for Medicaid only if they have absolutely nothing, not even their own home. The State of California just recently changed that. They said, "yes, you elderly people can have your own home". But other States do not have that.

In view of the fact that these conditions now exist, and that we find a program that is reducing care for the elderly, what is the answer? Is the answer to this, perhaps, a good national health plan? What is your opinion, Mr. Schaefer? I want to ask you that, and then maybe the Governor can comment later.

Mayor SCHAEFER. You have so many statements in there in the question. Many of the elderly in Florida are not poor. They go down to Florida because in some respects they can take care of themselves. In Baltimore, when I said 40 percent of the State's poor live in the city of Baltimore, they come there for a specific purpose or they stay there for a specific purpose because someone in the city will be worried about them and try to take care of them and come up with a program. And we have utilized most of the Federal programs to do what you say.

What is the answer? Well, first of all, we are in this transition stage, and I am part of it, to get everyone out of the hospital as fast as possible so that we can reduce health costs. I had never really thought out what the consequences would be until Dr. Guarnieri said to me, "That's very nice, Mayor, what is your long range plan, what is your thinking as these people come out?" And given the cases that she cited for me, I have got to start considering a long-range plan. I have got to develop a program like that the Governor has in Florida for the city of Baltimore.

Now, a national program is the answer. I think that is absolutely right, because there is an intervening measure of government between the Federal Government, and there is the State and there is us. The State keeps telling me that they can't do more, they can't do more. They expect us to do more for ourselves. That is the city role they see.

Well, the city has most of the poor and an already high tax rate, there is going to be a point where we can't do more for ourselves.

The CHAIRMAN. And neither can the poor because they are too poor.

Mayor SCHAEFER. There is one statistic that I use. One-third of our people pay taxes, a lot of taxes; one-third pay some taxes and one-third pay no taxes.

What I am saying is, some people in the city pay a whole lot. I don't pay enough of my real estate taxes to cover the cost of police and fire protection that I receive. And there is another group that lives in the city of Baltimore, this poor that we are talking about that pay nothing; they can't pay.

Do you know what worries me? As I get older, I am worried that I won't have enough to stay independent of medical costs. One big serious illness and I am wiped out. And I don't want to be wiped out. I don't want to live continually under the fear that someday nobody's going to be worried about me, and I am not going to have anybody caring about me. Now, you say, well, that's your problem and not mine.

I'm not sure it is my problem alone. I think we have got a duty. If I get older, and my life expectancy is continued I don't want to feel that I am obligated and have to beg somebody. I'd like to have that program that I spoke of before. I can go to the hospital, I can get out of the hospital and somebody will take care of me at home. Now, that is much, much cheaper. We can do this.

Congresswoman, you ought to ask one question. What would I do if I had one wish? My one wish, I would get all these people together, all these providers and all these people, and I would sit them down and I would say, OK, now here is the problem. You are kicking them out of the hospital early, what are you going to do? What are you going to do?

There is an answer to this. There is an answer, and the answer is in this program that will set up a home care program. People aren't going to cheat. There are two concerns: are people getting the proper care and are they getting too much care.

The CHAIRMAN. Ms. Bentley, would you like to respond?

Mrs. BENTLEY. Well, I didn't talk about the money. I was just asking about the one wish that the Governor had. And I think what the mayor has suggested here is probably an excellent approach, Mr. Chairman; namely, that we do get all of them and sit around and do a brainstorming session.

And I do want to comment, Mr. Chairman. I didn't have the opportunity at the opening to introduce Mayor Schaefer, even though he is not directly from my district, he is so close that I can reach out every day and touch him. And Baltimore County, which is my district, and Baltimore City are so interrelated and interdependent that whatever happens in Baltimore City dramatically affects Baltimore County and vice versa.

Like myself, I sit on a board of a hospital and a nursing home in Baltimore City as a matter of fact. And therefore, I want to point for the record, Mr. Chairman, that we are all very pleased and proud by the accomplishments of Mayor Donald Schaefer of Baltimore City. He has brought new life, new jobs, and new hope to the entire Greater Baltimore Area, and everyone there is so pleased with what he has done. He is almost like the Pied Piper. I think he could play a flute and everybody would follow.

He is looked upon truly as a fairy godfather of the area. And when he says that he is concerned, he means it. And when he says in our country that we should help the elderly, he means it, and I agree with him. The mayor noted that 20 percent of Maryland's population of the elderly, 65 and older, is in Baltimore City, and I might note that in Baltimore County, 22 percent of the population is 60 and over.

As a matter of fact, my husband and I contribute to that figure. So we do have a vast concentration of the elderly in that metropolitan area. And I am equally concerned with him. Maryland happens to be one of the four States, Mr. Chairman, that has been granted waivers by the Department of Health and Human Services in relation to the handling of Medicare payments because Maryland was in the forefront of cost containment of hospital expenses.

However, this does not exempt Maryland from applying the limited hospital stays. We don't fall right directly under the DRG Program, but we have to follow the general criteria. Of the whole area, as a result, we have many empty hospital beds, and the mayor is familiar with that problem. We have had many layoffs of employees at the hospitals as a result.

Mr. Mayor, do you think it might be feasible that the hospitals could set aside a certain portion of those empty beds for intermediate care? In other words, this concern about those who are sent home because their 5 days are up or their 7 days are up, maybe have intermediate care in these portions of the hospitals that are closed off today where they can stay—the patients can stay another 3 or 4 days, particularly the elderly, and the cost would maybe be in the $50 to $75 area rather than the $150 to $300 arena, which would reduce the cost but would give these people the extra little care until they're able to really move around on their feet.

Do you think that is a possiblity we might play with?

Mayor **Schaefer**. It is a possibility, but I would not recommend it right now. The reason I wouldn't is because I don't think we are in a position to do it. I think we are pushing people. And I think if you utilize those beds that way immediately, they are going to get right back again to the hospital care. I would rather wait a little bit longer and see what happens—well, we have a report coming on reduction of beds.

As the reduction of beds comes in and we see what we have to reduce, then go into a different type of thinking. My own people that Dr. Guarinieri and I are going to spend our time thinking about is home care, out of the hospital, into the home setting, because as you get older, and I remember from some personal experiences, the older people do not want to go into institutions. They don't want to go into nursing homes. Where they want to go is into their own house.

Mrs. **Bentley**. That's right.

Mayor **Schaefer**. And it is tough on a family when they have a parent who is elderly who they can't care for anymore. It is a wrenching existence for the person who must make the decision, but it is also difficult on the other side. And this program the Governor has I just think is great. I think that is a wonderful program. And I think that is something we are going to very seriously think about.

The CHAIRMAN. All right, the time of the gentlewoman has expired.

Mr. Gekas.

Mr. GEKAS. Thank you, Mr. Chairman.

I wish the lady from Ohio to remain because she had seemed to take a swipe at the administration when she at least implied that the administration dismisses home care as a utilitarian way to provide health care. I hope that the witnesses here understand that we cannot in trying to arrive at solutions here, attribute ill motives to the administration or to anybody involved in this process, rather it seems to me that the administration was trying to foster the kinds of programs and to promote the kinds of programs and to encourage the kinds of programs which the Governor has enunciated in trying to deal with health care as an alternative.

I do hope that the two witnesses share in my feeling that the administration faced with deficits, faced with maintaining an economy which makes all these programs possible in the first place, and to maintain it is just as important, is not interested in eliminated home care, but rather to put it in a different context given the deficit problem.

Mayor SCHAEFER. Mr. Congressman, let me answer that by saying anything the Federal Government does for me, I appreciate.

Mr. GEKAS. Does to you.

Mayor SCHAEFER. If you give us a program, we try to work it to get the best benefit for the tax dollar. If the program is gone, it is gone. I am a realist. We work with what we have. I heard what the Congresswoman said. I hear what you are saying. I think the Governor and I are not concerned over Republicans or Democrats. I think we are worried over one thing, elderly people.

Mr. GEKAS. Of course.

Mayor SCHAEFER. And I think he has evidenced this, in my opinion, and you have got to make some priorities. Now I think we have a duty to the elderly. I believe this. I believe—you see, the Governor touched on something that we are not going to get into today. That is prevention, nutrition. The cutback on the Nutrition Program, I don't think you would deliberately do that. I don't think you want to hurt people.

Maybe we haven't been able to convince you of the importance of the Nutrition Program, Meals on Wheels, and what it does for people. It is the only contact that some people have with the outside world.

Housing for the elderly, I have had people stand beside me and say, "This is the closest I'll be to heaven until I get there," because you provided the money for the homes for the elderly secure, and the same way we are in health care right now. And I don't want to go into sermons, but health care is a big problem.

Governor GRAHAM. I agree with the mayor. This is not a partisan issue. Everyone has a commitment to see that we meet our national responsibilities to those citizens who built this country, defended it, gave it to us to continue. I would urge, however, that in looking at the economic side, that we not fall into the trap of asking what is in the best interest for the end of this fiscal year and, instead, take a longer view.

Clearly, if all of the programs other than hospital care were eliminated it would be fiscally advantageous to the Federal Government from now until the end of September. It would be disastrous for the Federal Government for the 12, 24, 36 months thereafter. So we all share the concern about the financial condition of America. The question is: Do you take a short view or a strategic longer view of what is in the interest of both the citizens being served and the general taxpayers who are going to have to pay for those services?

My belief is the long view—for both the elderly American and all Americans—is an investment in less confining, less institutional, more prevention-oriented, community-based programs.

Mr. GEKAS. It is possible that this administration has the long view that that should be—these programs should be mutually shared. The long view for reducing costs is for steady replacement and cooperation between the local governments, State governments, and Federal Government.

I have no further questions.

The CHAIRMAN. Governor, I would like thank you—Governor Graham and Mayor Schaefer, for very excellent testimonies. We said about 15 minutes ago that you only had 5 minutes left, but we kept you longer than that. Your testimony has been most excellent, and you have helped the committee a great deal.

Thank you very much.

The committee will now hear from a panel of expert witnesses composed of Mrs. Catherine Ladner, Mr. Gordon Walker, Ms. Elaine Brody, Mr. Stephen Yovanovich, Mrs. Karen Struve and Dr. Suzanne Knoebel.

I am going to ask these witnesses if it is possible for them to summarize their testimony, include their written text in the record, it will appear in the record at this point.

I am going to ask Mrs. Catherine Ladner to start off the discussion.

A PANEL OF WITNESSES, CONSISTING OF CATHERINE LADNER, ON BEHALF OF HER MOTHER, RUBY MOBLEY, LUMBERTON, MS; GORDON WALKER, EXECUTIVE DIRECTOR, JEFFERSON AREA BOARD FOR AGING, CHARLOTTESVILLE, VA; ELAINE BRODY, ASSOCIATE DIRECTOR FOR RESEARCH, PHILADELPHIA GERIATRIC CENTER; STEPHEN YOVANOVICH, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSES ASSOCIATION OF BUTLER COUNTY, INC., BUTLER, PA, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE AND THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES; KAREN STRUVE, PRESIDENT, WALKER METHODIST RESIDENCE AND HEALTH CARE SERVICES, INC., MINNEAPOLIS, MN, ON BEHALF OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING, AND AMERICAN HEALTH CARE ASSOCIATION; AND SUZANNE KNOEBEL, M.D., PROFESSOR OF MEDICINE, UNIVERSITY OF INDIANA

STATEMENT OF CATHERINE LADNER

Mrs. LADNER. My name is Catherine Ladner. I am the daughter of Mrs. Ruby Mobley. My mother is home, but——

The CHAIRMAN. Will you please speak into the microphone, we cannot hear you.

Mrs. LANDER. My mother is homebound with serious illnesses at this time, and she has therefore asked me to appear before this committee for her and read to you her testimony. My mother's testimony is as follows:

> My name is Ruby Mobley, and I live in Lumberton, a rural Mississippi town. I am 86 years old, have been widowed since 1941, and have raised three children alone. I draw $297 monthly social security and live in government-subsidized housing.
>
> I have had serious medical problems since 1979, and first received home health services that year. My medical condition has deteriorated since June 1983. In June 1983 I was discharged from the hospital following only a few days stay for a life-threatening illness. I have recently been hospitalized three different times and twice sent home still very ill. After being seen by the home health nurse, I was readmitted to the hospital by my physician.
>
> Each time I was told that they could readmit me under a different diagnosis than I was previously hospitalized under. I don't understand why I have to be sent home from the hospital before I am able to be managed at home by the home health agency. It is my understanding that hospitals are getting their Medicare money from patients stays in the hospital differently than they did a few years ago. What I don't understand is why we elderly have to suffer for how the hospitals get paid.
>
> In April of 1984, I was notified that my home health visits would no longer be covered by Medicare. The notice stated that the visits were not "reasonable and necessary." I was very angry, upset, and frightened about my home health visits being cut off. I could not understand why the home health agency stopped my visits, and I was afraid of what would happen to my health without the nursing visits. I did not understand at that time that an insurance company working for the government had cut off the visits. I blamed the home health agency then, but I now know the visits were terminated by the insurance company which was working for the government.
>
> The home health visits stopped in April of 1984, as soon as I got the notice of termination. I requested a reconsideration of my case, and when that was denied, I asked for a hearing. However, I was not receiving any home health visits from April 1984 through August 1984 while waiting for hearing. I have Medicaid, but all it will cover in Mississippi is a few of my medicines and my hospital deductible and coinsurance.
>
> Since I was on Medicare, home health was not covered by Medicaid. While I was waiting for the hearing my medical and physical condition deterioriated rapidly. In August of 1984, I was hospitalized with a C.V.A., also known as a stroke. When the home health nurses were seeing me, they were constantly checking for signs and

symptoms of problems like this, and if the symptoms showed I was in danger of my circulation problems causing a stroke, they would take appropriate action to prevent the stroke. However, since I was not receiving the home health visits in August of 1984, the nurses were not there to prevent my stroke. I am convinced that my stroke would not have occurred or would have been much less likely, if the home health services had not been terminated. This is especially frustrating because the stroke occurred while I was waiting for a hearing on my case.

In March or April or 1985, while I was waiting for my hearing, I received a letter and form which said it was part of a survey being conducted by the Health Care Financing Administration. A copy of this form is attached to my written testimony and marked Exhibit A. I did not understand what this form was for or what it would be used for. I have since learned that patients who marked this form in the wrong way had their request for hearing dismissed. Fortunately, my daughter helped me fill out the form in such a way that my case was not dismissed.

After we sent the form back, I received a note asking my daughter to call about my case. A copy of this note is attached to my written testimony and marked Exhibit B. My daughter did not call in response to this note because she learned that when other patients made the same call, the person tried to talk them into withdrawing their request for hearing. My daughter, therefore, did not call the number because we did not want our hearing to be dismissed.

It seems very strange to me that the government would give me the right to Medicare medical care and if denied a hearing, the same government would take this right away. In May of 1985 a hearing was finally had on my case, over a year after my home health benefits were terminated. The hearing on my case was held with my daughter present as my representative. The evidence in my case was so convincing that the judge stopped the case in the middle of our presentation and ruled for me. A copy of the decision on the Administrative Law Judge is attached to my witten testimony and marked Exhibit C. The judge held that my Medicare benefits should not have been terminated. While I am glad that we won my case, I believe my stroke could have been prevented had it not been for the original denial of care. As a result of that denial of care, my health cannot be reversed to how it was before the stroke.

I am back on home health services now. The value of these home health services to my life and health was demonstrated this past May when the home health nurse found a serious kidney problem that I did not realize I had. Because of the quick action of the home health nurse, I received prompt treatment and what could have been a very serious and life-threatening illness was cured before it became life-threatening.

In conclusion, I would like to point out that, Number 1, because of my advanced age and serious medical problems, I badly needed the medical services provided by the home health agency. Number 2, I have needed more time in the hospital due to my many medical problems, but am sent home each time as sick as when I went into the hospital.

I wanted to blame my doctor for not letting me stay in the hospital long enough. He told me he had no control over my length of time in the hospital. I then wanted to blame our small rural hospital and even tried a larger hospital on the Mississippi Gulf Coast, all to no avail. Had it not been for the home health agency taking a chance and caring for me prior to the hearing, I don't know what I would have done.

I believe the Medicare and Medicaid benefits are invaluable to older persons such as myself who have serious and life-threatening illnesses. The home health medical services which are covered by Medicare are especially important to us because in many cases we can manage illnesses at home if we have periodic skilled nursing visits to assist us.

However, the Medicare benefits do not help very much when they can suddenly and arbitrarily be taken away by the insurance company that administers the program for the government. For an elderly person with serious illnesses, such as myself, a lot can go wrong in the year or more that it takes to get a hearing on the denial. The stroke I had while waiting for my hearing is a prime example of this problem. It is also my understanding that like me, many other sick and elderly people have had serious complications and problems arise after their home health services were terminated, and some have even died shortly after the home health visits were cut off.

The value of these Medicare benefits is also diminished if we are discouraged from exercising our right to a hearing. I do not understand why the government gives us the right to a hearing and then tries to discourage us from using that right. And who knows, the very skilled nursing visits I am not receiving may be denied two, three or even four months from now. My children help a lot, but they are not doctors or nurses. But I wish they were. I would not be fighting the system I am fighting today to receive the care necessary to sustain my life. I would like to remain in my own home.

I would like to thank each member of the committee for taking the time to listen to my story.

The CHAIRMAN. Thank you.

[The exhibits submitted by Mrs. Mobly follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES Social Security Administr[illegible]

[illegible] Mobley
[illegible] Avenue
Lumberton, MS 39455

[illegible]-7214

Dear M.s Mobley:

As part of a study being conducted by the Health Care Financing Administration in Atlanta, GA, we have been asked to contact you for information about the attached copy of the request for hearing/reconsideration.

Please answer the following questions and then sign your name in the space provided. Enclosed is a postage-paid envelope to be used in returning the questionaire to our office.

If you have any questions about the questionaire, call our office and ask for Mr. Hooker or Mr. Connell. Your prompt reply will be appreciated.

Sincerely,

Charles W. Williams

Charles W. Williams
District Manager

1. Did you sign the attached request for a hearing /reconsideration?

   [✓ YES] NO

2. If you did sign the form, did you understand what you were signing?

   [✓ YES] NO

3. Did someone from Home Health Agency Multi County ask you to sign the form?

   YES [✓ NO]

4. If you signed the form, do you still want a hearing /reconsideration on the Medicare denial?

   [✓ YES] NO

SIGN HERE: Ruby Mobley by [illegible] DATE: 4/10/85

Exhibit "A"

Social Security

PLEASE ☐ Come in the Social Security Office

☒ Phone 205-832-7503

MRS. LADNER: IT IS MOST IMPORTANT THAT I TALK WITH YOU REGARDING THE HEARING THAT HAS BEEN SCHEDULED FOR YOUR MOTHER, RUBY MOBLEY. PLEASE CALL ME AT THE ABOVE PHONE NUMBER AS SOON AS POSSIBLE

THANK YOU

Hours 7:00-3:30
Monday–Friday Except National Holidays

Ask for MRS. COTTEN in Judge Akers'office

This concerns The hearing scheduled for Ruby Mobley 5/22/85 at 1:45 P.M. in Hattiesburg,MS.

SSN 425-24-3973A

If you are going to visit the office, please bring this card and the following items with you:

FORM SSA-2708 Previous Revisions May Be Used

Exhibit "B"

Re: Ruby Mobley

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social Security Administration
ADDRESS:
OHA
P. O. BOX 4360
Montgomery, AL. 36101
OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

Postage and Fees Paid
U.S. Department of H.E.W.
HEW 397

U.S. MAIL

Mrs. Catherine M. Ladner
c/o Mrs. Ruby Mobley
908 Camp Ave.
Lumberton, MS. 39455

NOTE TO PROCESSING CENTE
FURTHER ACTION
NECESSARY

[illegible]

Name and Address of Claimant

Ms. Ruby Mobley
908 Camp Ave.
Lumberton, MS. 39455

PROVIDER:

Home Health Agency Multi-County, INC.
P. O. Box 3409
Hattiesburg, MS. 39401

NOTICE OF FAVORABLE DECISION
PLEASE READ CAREFULLY

The enclosed administrative law judge decision is favorable to you, either wholly or partly. *If you are satisfied with the decision, you need not do anything.* Your file has been mailed to another office for processing of the decision. You will be contacted by that office or your local Social Security office if further information is needed from you. *If you are contacted, please respond promptly in order to prevent delays.* As soon as action on the decision has been completed, you will be notified in writing.

If you disagree with the decision, you have the right to request the Appeals Council to review it within 60 days from the date of receipt of this notice. It will be presumed that you received this notice within 5 days after the date shown below unless you show us that you did not receive it within the 5-day period. You (or your representative) may file a request for review at your local Social Security office or at the hearing office. The request can be made either in person or by mailing a letter to these offices. You may also mail the request for review directly to the Appeals Council, Office of Hearings and Appeals, SSA, P.O. Box 3200, Arlington, VA 22203.

The Appeals Council may, however, within 60 days from the date shown below, review the decision on its own motion (20 CFR 404.969 and 416.1469). This could result in a change in the decision. After the 60-day period, the Appeals Council generally may reopen and revise the decision on the basis of new and material evidence, or if a clerical error has been made as to the amount of benefits, or where there is an error as to the decision on the face of the evidence on which it is based (20 CFR 404.988 and 416.1488; 42 CFR 405.750 and 405.1570). The Appeals Council will notify you if it decides to review the decision on its own motion or to reopen and revise it.

Unless the Appeals Council reviews the decision on its own motion, or you timely request review, you may not obtain a court review of your case (sections 205(g), 1631(c)(3) or 1869(b) of the Social Security Act).

This notice and enclosed copy of
decision mailed
MAY 31, 1985

cc:
Name and Address of Representative:

Ms. Katherine Ladner
P. O. Box 568
Poplarville, MS. 39455

ATTORNEY FOR PROVIDER:

Mr. Wayne Hynum
Box 654
Hattiesburg, MS.XXXXX 39401

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

DECISION

In the case of:	Claim for:
Ruby Mobley	Hospital Insurance (Part A, Home Health Services
(Claimant)	
Home Health Agency Multi County	425-24-3973A
(Provider)	(Social Security Number)

This case is before the undersigned Administrative Law Judge upon a request for hearing timely filed by the beneficiary, Ruby Mobley, expressing dissatisfaction with the reconsideration determination concerning services furnished during the period February 1, 1984, through April 19, 1984.

ISSUES

The general issue to be decided is whether the services to beneficiary during the period February 1, 1984, through April 22, 1984, are covered under the Medicare program as Home Health Services.

LAWS AND REGULATIONS

Section 1811 of the Social Security Act, as amended, provides, in effect and as pertinent here, for protection against hospital, related post-hospital, home health services and hospice care costs for individuals who are 65 years of age or over and eligible for retirement benefits under Title II of this Act.

Section 1812 of the Act provides, as pertinent here, that the benefits provided to an individual by the insurance program under this Part shall include entitlement to have payment made on his behalf for "... (3) Home Health Services:".

Section 1862(a) of the said Act provides, as pertinent here, that no payment may be made under Part A for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member or which are not reasonable and necessary for the prevention of illness or where such expenses are for custodial care.

Section 1879(a) provides, in effect and as pertinent here, that where a determination has been made that payment may not be made for items or services furnished because they are excluded under 1862(a)(1) or (9); and both the beneficiary and provider did not know and could not reasonably be expected to know that such payment would not be made, then payment would be made notwithstanding the determination.

Subsection (b) provides, in effect and as appropriate here, that in such cases of payment for excluded services except the provider should have known that payment could not be made the Secretary shall indemnify the beneficiary for any such payments and such payment shall be considered an overpayment recoverable from the provider.

Subsection (c) provides, in effect and pertinent here, that no payment shall be made under this section if both beneficiary and provider should have known that such items and services were excluded under 1862(a)(1) or 1862(a)(9).

Subsection (d) in effect, in cases arising under (b) and (c) above, extends the same appeal rights to providers if it has been determined that the beneficiary will not exercise such rights.

In summary, the appeal rights extended to providers under Section 1879 are limited to those involving items or services excluded under 1862(a)(1) or (9); and then only those not covered under waiver of liability in which a determination has been made that either the provider or both the provider and beneficiary knew or should have known that the said exclusions would apply. Any waiver applied to any items or services not so excluded would be inappropriate.

At the hearing the beneficiary appeared through her daughter and authorized representative, Ms. Catherine [illegible], and the provider was represented by the Honorable Wayne Bynum, practicing attorney of Hattiesburg, Mississippi. Testifying as a witness on behalf of the provider was Ms. Hilda Parker, register nurse, who is employed by the provider.

The testimony in the record in this case established that the beneficiary was admitted to home health care on July 20, 1983, with a diagnosis of gastroenteritis, high blood pressure, chest pain, osteoarthritis, hiatal hernia and a slow heart rate. The testimony presented a picture of an aged and debilitated patient, whose condition was deteriorating. On March 27, 1984, her blood pressure dropped to 80/50 and her attending nurse immediately contacted her treating physician. On one other occasion during the period in issue she, the attending nurse, contacted the physician. The record also establishes that the nurse met with the supervisor during March to discuss the beneificary's particular problems.

On August 2, 1984, this beneficiary was hospitalized with a cerebral vascular accident with left hemiparisia, less than four months following her discharge to self-care. This in and of itself is a strong indication of her need for skilled care on a weekly basis during the period in issue. Certainly at this point she is a high risk candidate for recurring strokes. There is of course no way of knowing whether continued skilled visits on a weekly basis would have prevented this stroke but certainly the prevention of such occurrences is one of the primary reasons for the existence of the program. The beneficiary's overall condition would support a finding that recovery and safety can be assured only if the total care is planned, managed and evaluated by technical or professional personnel. The undersigned Administrative Law Judge concludes, therefore, that the nursing visits made to this beneficiary during the period at issue constituted a skilled level of care and were reasonable and necessary under the circumstances.

FINDINGS

Based upon the evidence of record and consideration thereof, the Administrative Law Judge makes the following specific findings:

1. The beneficiary, Ruby Mobley, received home health services from the provider, Home Health Agency Multi-County during the period February 1, 1984, through April 19, 1984.

2. The services constituted a skilled level of care and were reasonable and necessary for the diagnosis and treatment of beneficiary's illnesses.

DECISION

It is the decision of the Administrative Law Judge that the beneficiary, Ruby Mobley, is entitled to have payment made in her behalf for services furnished by Home Health Agency Multi-County during the period Februay 1, 1984, through April 19, 1984.

G. M. Akers
Administrative Law Judge

Date: May 31, 1985

The **Chairman**. The Chair now recognizes Mr. Gordon Walker.

STATEMENT OF GORDON WALKER

Mr. **Walker**. I am Gordon Walker, executive director of the Jefferson Area Board for Aging, and Jefferson Area Board for Aging is one of over 600 area agencies on aging in the country, and there has been a lot of discussion today about who is responsible for the pooling and coordination of resources at the local level. And I would like to enunciate that our agencies on aging are responsible for that, doing the best job they can.

I have several case studies which I had selected to read, but I think in the interest of time and because of what you just heard, I will just limit it to one.

The **Chairman**. Will you provide anything that you may have for the record?

Mr. **Walker**. Yes.

The **Chairman**. Thank you.

Mr. **Walker**. This one case study is becoming very common, almost a daily occurrence, not just among this area agency on aging, but from other studies that are being done around the country. I will be speaking in just a moment to a study that we have conducted in Virginia.

This case is a rural resident, male, age, 72; lives with wife, age, 64. Had a severe stroke early in 1984. Was hospitalized for 2 months, discharged to a nursing home to be rehabilitated. Went home and received health care and family support. During the spring of 1985, however, he had another stroke. He was admitted to another hospital. He was released after less than 7 days.

His wife who is also frail did not believe he was well enough to come home. She was given no explanation for his release. He went home and become much worse the next day. The following day he died in an ambulance on the way back to the hospital.

DRG's may seem effective at controlling distortions and the funding bias of acute care. However, they do so without an attending commitment to long-term care services. Consequently, economic cost savings are jeopardizing health care accessibility and quality of care. We find that simply by not paying for care at hospitals does not necessarily result in the sudden absence of the need for such care. Instead the responsibility of providing care has shifted to nonhospital services creating unnecessary hardships because this burden has shifted without an appropriate and necessary commitment of resources.

The net result in many instances is a de facto rationing of care which, in turn, is closing off access to life-sustaining services. One thing I would like to note here is earlier testimony has talked about persons having to be transferred to more expensive care. What is of concern to me and other area agency on aging directors is that people are receiving no care. There just is not a care system out there capable of providing the care they need.

We have been talking about home health care. Home health funded under Medicare is one form of care, but we are also talking about many other types of in-home services. For example, in the State of Virginia, we have seen an increase of close to 50 percent in the number of home-delivered meals served in the last year. We have seen in the same amount of time 28 percent increase in home services, home care, personal care.

In addition to this, there are over 580 persons presently on waiting lists in the State of Virginia. These are the people who have been assessed as having verifiable needs for home delivered meals and in home services, people who are homebound who are not capable of doing for themselves. One other factor which is rather frightening is that in the past 6 months in the State of Virginia, we have witnessed an increase of 18 percent in reports of adult protective service cases. These are cases of abuse and exploitation. Although no conclusive data can prove that this 18-percent increase is directly a result of DRG's, many social service workers who are responsible for taking adult protective service referrals believe this increase is partially due to the family support system and the other care systems for the elderly being overtaxed and underdeveloped.

Let me say one other thing about this study that we have conducted in Virginia. We polled and surveyed during the past couple of months over 160 different care providers. These are people working at nursing homes, home health agencies, area agencies and family caregivers. What we see is a total breakdown in the system. The system is just not working, and it is not working for multiple reasons, many of which were discussed here today.

I would just like to reiterate that one thing that is of great concern is that the Reagan administration and I can't help but believe this is somewhat political, because that is what it is coming down to as far as where the dollars are coming from or not coming from—is using an equation to measure success of DRG's by the amount of hospital dollars saved. If, however, we apply human values and prudent medical ethics to this equation, then DRG's should be judged ineffective and a failure for many disadvantaged persons.

Clearly, all service providers have identified that care for sick elderly persons is progressively moving from hospitals to the community creating in many instances, financial and emotional costs for all care givers. It may be convenient and politically expedient to regard cost containment efforts in a positive light. If we fail, however, to thoroughly look at those who are carrying the burden of these costs savings, we are obscuring truths that should be acknowledged and acted upon.

It is sensible to control the growth of Medicare costs, but it is also prudent to preserve Medicare's social responsibility to provide adequate care for the elderly. We should continue to try and reach the goal of keeping people at home. We should do so, however, with adequate financial support for the long-term care health system and not in such a way as to endanger the patient's life and the breakdown of their support system. Thank you.

[The prepared statement of Mr Walker follows:]

PREPARED STATEMENT OF GORDON WALKER, JEFFERSON AREA BOARD FOR AGING, CHARLOTTESVILLE, VA

INTRODUCTION

The case studies you are about to hear are what a few clients on only one of more than 600 Area Agencies on Aging have experienced during the past year. Empirical studies and anecotal information from around the country strongly indicate that these situations are occurring with disconcerting regularity.

CASE STUDIES

An elderly white female, age 70, was released from a local hospital after surgery relating to cancer of the colon. She was released into the care of her elderly husband, who was unable to provide the care required. She was referred by the hospital to an area agency on aging (AAA) for homemaker service and to the Health Department for Home Health service. Assessments made by both the agencies within two days of discharge revealed that the patient required total care. The AAA homemaker program was fully subscribed at that time. The client died within a week after discharge, while the AAA and the Health Department were in the midst of putting together arrangements for limited care (I.E. periodic visits by a home health aide and limited homemaker hours pulled from another client).

White female, age 73, diabetic, double leg amputee, was released from the hospital less than a week after both of her legs were amputated. Her husband, age 72, is frail. There is no running water or bathroom in their house, so water has to be carried from a nearby creek. The Area Agency on Aging was contacted as a provider agency for medicaid personal care services. Not to exceed 18 hours per week. Patient was taken home from the hospital in an ambulance where in AAA staff person and a R.N. were waiting to begin personal care services. The patient was in great pain, barely conscious and the stump wounds needed dressing changes. She also needed insulin shots, but the husband and other family members were unable to administer them. The patient was incontinent. The situation was so critical that a nursing home bed had to be located immediately. She was taken to a nursing home facility two counties away from here home since no other nursing bed could be located.

Male, age 84, lived alone, elderly resident of a small rural county in Virginia. Family members lived close to him and provided support. During September, 1984, he had a stroke and was admitted to a public hospital. He was there three weeks when his family was told that he would be discharged. He was taken to the lobby where a secretary said that he looked too ill to go home. He was discharged but stayed in the lobby. He was running a high fever. A family member went and confronted the doctor. He was readmitted 15 minutes later with pneumonia. He was in the hospital another week, went home for a week and died.

Rural resident, male, age 72, lives with wife age 64. Had a severe stroke early in 1984. Was hospitalized for two months. Discharged to nursing home to be rehabilitated. Went home and received home care and family support. During the spring of 1985, he had another stroke. He was admitted to UVA hospital. He was released after less than a week. His wife who is also frail did not believe he was well enough to come home. She was given no explanation for his release. He went home and became much worse the next day. He died in the ambulance on the way back to the hospital.

Unfortunately, these are not isolated examples. They represent common episodes of the community and family support system attempting to cope with the shifting sands of health care policy. These changes, specifically Diagnostic Related Grouping (DRG's), have significantly altered both the health care delivery system and the type of health care delivered. Hospitals are now encouraged to discharge persons quicker or, in some cases, evern deny admission. This is deamatically and negatively impacting on the non-hospital continuum of care for the elderly and the well-being of the individual.

To date, much attention has focused on the impact of DRG's on hospital costs and to some extent hospital services. Proponents of this method of cost containment are quick to point out the dramatic reduction in hospital expenditures, admissions and lengths of stay as clear evidence of the appropriateness and success of the system.

Data, of course, support the above claim. Admissions rates are down by 4 percent, average lengths of stay have dropped from 9.5 to below 7.5 days, and hospital costs went up a moderate 4.5 percent when before DRG's the rate was over 10 percent. Nonetheless, to some extent this claim is one that is based on gross receipts without consideration of the costs incurred in the process of acquiring as gross income. To correctly measure if the prospective payment system (PPS) is working, we should look beyond the hospital and into the homes of the frail elderly and also look at the capacity of community services to adequately meet the patients' health and social needs.

The intent of this discussion is to focus on some of the costs incurred within key elements of the long term care system. Specifically, this discussion will focus on the effects on DRG's on costs of care for non-hospital components of the health care system including nursing homes, AAAs, home health services and families of patients.

This discussion will, hopefully, document that simply not paying for particular care at hospitals (acute care) does not necessarily result in sudden absence of the need for such care. Claims of hospital savings obscure other costs. The burden of care has shifted to the non-hospital service system and families. This shift in itself is neither good nor bad. The difficulty arises because the burden for care has occurred without an appropriate and necessary commitment of resources (financial, educational, programmatic, and research). The net result in many instances is a rationing of care which is closing off access to life sustaining services.

This oversight of policy makers in their haste to cut hospital costs is one based on ignorance, rather than malicious neglect. Because our magic bullet, the hospital centered health care system, has been the dominant mode of health care for the past half century, not even health care providers could offer a rationale view of what was needed to cost effectively accommodate the demands for non-hospital health services with the implementation of DRG's.

PPS and DRG's seem effective at controlling distortions in the funding bias of acute care. However, they do so without an attending commitment to long term care services. The net effect being economic cost savings which jeopardizes quality of life and health care accessibility.

Now the changes are upon us. Information in the media and from service providers are daily providing evidence of long waiting lists for home delivered meals, families being overwhelmed by the constant acute care they must provide older family members, the paucity of nursing home beds and personnel trained to provide the level of care required by patients discharged from acute care facilities, increased demand for in-home acute care nursing, and finally a lack of policy and reimbursement structures capable of supporting and assessing access of necessary care, let along some quality of care.

Evidence of these costs comes from not only personal accounts but also from a state wide longitudinal study of the Impact of DRGs on Community Health Services for the Elderly in Virginia and regional reports around the country.

Perhaps the most encompassing change which DRGs have imposed on families and non-hospital health care services is the demand for complex services to frail, dependent patients who previously were allowed to gain strength in acute care hospitals prior to discharge. While DRG's have obviously affected younger as well as older patients, the hazards associated with health care of the elderly are considerably greater than for younger patients. This is true because of psychological and physiological vulnerability in the elderly which make them likely candidates for (1) slow recovery, (2) idiosyncratic responses to treatment, (3) agitation and confusion associated with impaired physiologic status and (4) environmental changes incurred when short stay hospitalization is imposed.

These vulnerabilities in the elderly patients discharged to nursing homes, families and home health care agencies coupled with the increased numbers of such patient referrals have resulted in a total overload for community health services and families. From investigations currently underway, it is clear that families and community service agencies are very concerned about providing adequate care but their capacities are being rapidly exhausted.

In Virginia, for example, during the first quarter of 1985, hours of in-home services performed by Virginia's twenty-five area agencies on aging increased by 49 percent from a year earlier. Home delivered meals are up 28 percent from the previous year with several AAA's reporting increases of over 50 percent. As of June 1, 1985, 13 of Virginia's AAA's reported having waiting lists for home delivered meals with an additional six having recently reached capacity. The number of frail, at-risk persons in need of these services has grown to 590. If demand continues at its present pace, the number of persons waiting for meals is expected to incresase dramatically, thereby advancing the likelihood of institutionalization. Also, 8 AAA's are forced to deny other in-home services to 286 impaired older persons due to insufficient resources. For persons receiving services, many are beginning to receive less meals or less hours of home care. Thus leaving many of them without the level of services needed to either maintain or improve their health.

A May, 1985 survey of all AAA's in Virginia estimates a potential $5–6 million budget deficit over the next fiscal two years. This situation occurs as AAA's try to maintain present service levels and does not take into account the expected increasing demand for home care and home delivered meals.

This exhaustion not only restricts access of older patients to care and lowers quality of care. But also grossly interferes with other responsibilities of families and community service agencies and will result in iatrogenic effects with serious consequences for all family members and clients served by community health agencies.

Quite simply, community service agencies are becoming less able to provide other services to other clients or preventive services to any clients because of acute care demands. Several area agencies on aging are cutting back on congregate meal sites and other supportive services so as to meet the increasing demand for in-home services to those at greatest risk of institutionalization. In the Charlottesville, Virginia area, for example, many sites are now open only 2 or 3 days a week as limited resources are being redirected to respond to the demand for life sustaining services. The long term effects of this decrease in the provision of preventative services for the relatively well elderly signals an ominous future for many of the persons receiving services at the congregate sites who sit precariously on the edge of serious illness.

The nurturing, economic, socialization functions of families are taxed to the degree that elder and child abuse are likely to increase. Witness in Virginia, for example, the 18 percent increase from September, 1984, to April, 1985, in adult protective service referrals for persons over the age of sixty. Although there is no conclusive proof this phenomenon is a direct result of DRG implementation, interviews with social workers responsible for handling these cases of abuse. Neglect or exploitation believe that much of this increase is a direct consequence of family members and other care givers finding it extremely difficult and more stressful to provide intensive care to sicker persons.

Caregivers, for the most part, want to provide loving but may find themselves burned out by the increasing demands on their time and energy. Consequently, caregivers syndrome—stress caused by the intense health care requirements of a family member and lack of adequate services—has become a frequent condition. In addition, functional adult children caring for elderly parents are experiencing physical and emotional illnesses interfering with their capacities as workers and care givers. Families are being asked to do more when in most cases they have already done everything they can. Is it not unjust to ask them to deal with intensive disabilities and other complications as well as higher out-of-pocket costs? It is demoralizing to the family not to be able to provide the care needed or to become a pauper in order to receive certain kinds of health care.

Evidence of the implications of DRG's is documented by a Virginia survey of 160 care providers representing nursing homes, home health agencies, hospital discharge planners, families and area agencies on aging. A preliminary analysis of data strongly points out that the health care system for the elderly is changing dramatically from the pre-DRG era. This investigation clearly reveals:

(1) Decreased length of stay for elderly in acute care settings;

(2) Decreased length of time spent in community between acute care admissions for elderly patients;

(3) Increase in volume, complexity and intensity of skilled home care and home support services for the elderly;

(4) Increase in complexity and acuity of skilled nursing home care;

(5) Increase in all levels of personnel in nursing homes; and

(6) Increased involvement, stress and strain of families of the elderly;

Consistently, community service providers and hospital discharge planners identified and ranked the greatest needs for services to the elderly post DRG's as (1) home health skilled nursing care and skilled nursing home beds, (2) home health aids, and (3) meals on wheels.

In reference to the increased needs for home health care skilled nursing services, a paired T-test (P=.982) documented a significant increase in these services provided by home health agencies from pre to post DRG's. The need for these services is substantiated by caregivers reporting that the populations of elderly served pre DRG's was predominantly ambulating with assistance to post DRG status of chair or bedridden. Care givers report an increase in the use of mechanical equipment in care and an increased length of time and frequency of visits required for adequate care. Family members substantiate this increased need and their frustration about their limitations in providing care by proposing that they don't feel competent and they need more frequent assistance by home health nurses than is currently available.

Area agencies on aging and other community service agencies are equally concerned about the disruption of service to chronic long term clients because of the multiple crisis short term acute demands of newly discharged elderly clients and emergency interventions for elderly patients requiring re-admission. These organizations also report:

(1) Family members are having to leave jobs and family to care for discharged patients because they are not given adequate time to set up services. The degree of care required is exhausting spouses and other family care givers who must often provide 24 hour patient care while trying to maintain jobs and their own nuclear families.

(2) Last minute referrals from hospitals.

(3) More staff needed to handle increased patient load that necessitates more intensive care and longer hours.

(4) Greater use of high-tech services.

(5) Inability of resources to meet growing demand for in-home services.

(6) Greater demand for special diet meals and prescribed nutritional supplements.

Discharge planners are experiencing similar situations. The major implications DRG's are creating for discharge planners include:

(1) Lack of availability of ICF and SNF nursing home beds.

(2) Length of stay reduced by 10%, thus, in many cases, providing insufficient time to prepare appropriate discharge plans.

(3) More nursing home placements of patients with complex medical needs.

(4) Sicker persons returning to the community.

(5) Increased demands being made on family and the community.

(6) Increasing pressure from physicians to discharge patients quicker, and

(7) Insufficient community resources.

Nursing homes report:

(1) A doubling in patient physical treatments (hyperalimentation, IVs, jet aerosol).

(2) Increased weekend admissions.

(3) An increase in agitation and confusion among patients.

(4) Increased number of deaths.

(5) An increased need for skilled, trained personnel and medical equipment, and

(6) Placement of patients with intensive care needs in ICF beds because no SNF beds are available. These effects on nursing homes are much more significant than appear on superficial examination.

It is widely recognized that the bulk of nursing home care is provided by less than high school educated nurses aides who have a documented turnover rate from 75–700 percent across the country. These aides are recognized as exceptionally poorly trained and even more poorly reimbursed. There are no enforceable standards for nursing aide education. Medicare, state licensure and JCAH expectations are totally inadequate in this regard. Many of these aides, while lacking nursing care skills, demonstrate truly remarkable nuturing, caring behaviors in their work with the elderly. These may be equally as important to quality care as nursing care skills. However, with acutely ill patients being admitted to nursing homes, nursing homes aides are frustrated by their lack of training and knowledge about required skills, and they do not have the time to nurture. This is likely to lead to possible patient abuse and/or increased turnover. Both of these likely outcomes are very hazardous for elderly patients as consistency, predictability and nurturing associated with knowing the care giver is of vital importance in quality care of the elderly.

A second major problem for nursing homes is that of agitation and confusion of an increasing number of elderly. This is problematic and a huge risk to individual patient safety. It also creates major difficulties for other more oriénted residents who cannot rest or interact socially because of the disruption created by such behavior in a nursing home environment. In many ways, the increased frequency of death in nursing homes creates the same problems as identified above. Residents and staff and the milieu of the nursing home are significantly affected and at this time are poorly prepared to deal with the social and emotional consequences of frequent death.

These Virginia findings are supported by a report from the Eastern Washington Area Agency on Aging. This report of 31 social and health agencies from the eastern region of the State of Washington drew the following conclusions:

1. General Effects of DRGs:

Changes have occurred in traditional care practices:

A. Overall shorter length of stay in hospitals;

B. More patients are being exposed to other services within the health care continuum;

C. Increased medical acuity of older patients being discharged from hospitals (frail older persons are being discharged "quicker and sicker" than previously practiced);

D. In-home care providers are being called upon to provide more short-term and intensive care;

E. Medical needs taking precedence over social needs, i.e., increased emphasis on emergency treatment and less emphasis on preventative, holistic care.

Resources utilization has shifted from hospital in-patient to hospital out-patient, home health and other community-based care services.

II. Effects of DRG's on Home Health Agencies:

A. The DRGs prospective payment system has had a significant impact on the extent and range of services being provided by home health care agencies. Further, the impact on urban providers has been more significant than on rural providers.

For urban home health care providers, the number of reimbursable home visits are up 27 percent, based on six months data comparable periods in 1983 and 1984 for agencies responding to the survey.

For rural providers, professional nursing visits are up 18 percent in 1984 when compared with the number of visits made during a comparable period in 1983.

B. The demand for the provision of professional nursing services in the home is up in both urban and rural settings.

In urban areas, professional nursing visits are up 37 percent, based on six months data for comparable periods in 1983 and 1984.

In rural areas, professional nursing visits are up 18 percent in 1984 when compared with the number of visits made during a comparable period in 1983.

C. Delivery of home health aids services is up in urban areas, it is down slightly in rural areas:

In urban areas, home health aide visits are up 22 percent based upon six months data for comparable periods in 1983 and in rural areas, the number of home health aide visits is down slightly in 1984 when compared with the number of visits made during a comparable period in 1983.

D. Based on prevailing reimbursement rates, it is conservatively estimated that the cost to all payers of providing in-home health care (professional and aide) during a six month period in 1984 in the seven eastern Washington counties surveyed is $244,211 greater than for the comparable time period in 1983.

E. In response to the increased medical acuity of patients being seen in the home, home health care providers are:

Purchasing, or planning to purchase, more sophisticated equipment (e.g., intravenous pumps, hospital beds, etc.).

Securing, or planning to secure, training for nursing personnel on topics ranging from the utilization of more sophisticated medical equipment and devices to the performance in the home of more complicated nursing procedures.

Experiencing an increase in the average length of time required to complete a nursing visit.

Experiencing an increasing number of short-term visits requiring intensive care.

Experiencing an increase in the utilization of traditional nursing supplies.

Experiencing an increase in the demand for the delivery of rehabilitative services. Especially speech and physical therapy services.

Experiencing an increase in the growth of staff nurses, aides and office personnel.

Experiencing an increase in weekend staffing and after-hours on-call availability of nursing personnel.

III. Effects of DRG's on Home Delivered Meals Programs:

A. The demand for the provisions of home delivered meals is up on both urban and rural settings.

In urban areas, the number of persons receiving home delivered meals are up 24 percent based on six months data for comparable periods.

In rural areas, the number of persons receiving home delivered meals are up 33 percent in 1984 when compared with the number of meals served during a comparable period in 1933.

The number of meals being served has increased 16 percent in urban areas and 26 percent in rural areas for comparable times periods.

B. One of every four clients served by both urban and rural meal programs during the first seven months of 1984 were DRGs-related.

C. Increased numbers of persons are receiving short-term meal assistance (I.E., less than two weeks).

D. In the Spokane Home Delivered Meals Program. The workload of volunteer/drivers has increased significantly from about 14 meal deliveries per driver to 22 deliveries per driver since the implementation or DRGs (meals are also arriving late).

E. Increased demand for special diets to individuals recently discharged from hospitals.

IV. Effects of DRG's on other community-based services:

A. There is a demand from care givers of family members recently discharged from hospitals for in-home Respite Care.

B. Increased demand from clients recently discharged from the hospital for the delivery of Chore Service on weekends.

C. Increased demand for emergency Chore Service, Inc., i.e. a request for service initiation within 24 hours of the time a referral for service is made.

D. Increased demand for multiple aide visits during a single work day (the aide goes into the home of a client more than once on a given day).

V. Effects of DRG's on patient's and families:

A. Medicare recipients and their families and/or significant others are generally uninformed, confused and anxious about prospective reimbursement under DRGs.

B. A high percentage of caregivers are experiencing high levels of anxiety and resentment over being "forced" into the uncertain role of caring for a sick loved one.

C. Hospitals are not giving patients/families the supplies they need to manage at home nor are hospitals providing the instructions necessary for appropriate follow-up care at home. As a consequence, families rightly tend to feel that hospitals and/or doctors have shifted the responsibility for providing care to the family and they have not been properly prepared for this new role.

VI. Estimated annual cost impact on the community-based service delivery system

	Estimated annual costs
Program impact area:	
Home health agencies	$244,211
Home Delivered Meals Programs	19,765
Spokane respite care demonstration project	5,000
Contracted Chore Services Program [1]	unknown [2]
	268,976

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[1] There was no empirical basis for providing a basis for projecting a cost impact of DRGs on the Contracted Chore Services Program. This is unfortunate because there is obviously a significant cost factor involved. One would reasonably expect the cost factor to be at least as high as the home delivered meals program.

[2] Unknown.

Further evidence of DRG impact on community and family support systems is presented in a report recently prepared by the Southwest Long Term Care Gerontology Center in Dallas, Texas. This survey of forty area agencies on aging representing a wide variety of geographical regions and urban/rural characteristics supports the data collected from the Virginia and Washington studies.

While measuring how case loads, program priorities and service delivery have changed since the implementation of DRG's, the statistics portray a situation of increased service demand and substantial increases in units of services provided. This phenomenon is exacerbated by a documented increase in the length of time clients receive in-home services, mostly noticeably in-home skilled nursing care and personal care.

Additional findings report:

1. One-third of the agencies having to decrease or eliminate some programs to increase funding for case management, homemaker services and home delivered meals. As we witnessed in Virginia, the services most often cut were senior center programs, congregate meals, transportation, volunteer services, counseling, education, home repair and chore service.

2. Increase in referrals from hospitals for emergency services, home care and home delivered meals. When asked what problems contributed most to hospital readmissions, the directors of these 40 AAA's most often believed inadequate home support services, inadequate family support, impaired physical condition and inadequate time for discharge planning were primarily responsible for avoidable readmissions. A large majority also believe that longer initial hospitalization and additional community resources would have prevented or delayed institutionalization.

Summary and implications:

Clearly, all service providers have identified the locus of care for sicker elderly patients moving from acute care hospitals to community agencies and facilities. This shift, while not necessarily negative, is also not without financial and emotional cost to agencies, families, care giver and older patients.

If the equation by which we measure success is hospital dollars saved, then DRG's and other cost containment efforts have succeeded. If, however, we apply human values and respectable medical ethics to this equation, then DRG's should be judged ineffective and a failure for many disadvantaged persons.

Nursing homes have experienced a significant increase in the needs for all levels of personnel since the institution of DRGs. Home health care agencies report an increase in the need for more complex and intense nursing services. Area Agencies on Aging are overburdened and underfunded with the demand for home delivered meals and in-home services which, in turn, is reducing preventative programs for the well elderly.

The requirement for care (equipment, skill, emotional sensitivity and resiliency) in community agencies have changed. Dying patients are no longer sent to the hospital. Families and care givers deal directly rather than indirectly with all the harsh realities of assisting a dying person.

Increased skills, use of sophisticated medical equipment and increased emotional demands on families and community care givers require increased training and support for these providers. Furthermore, shifting this care to community care agencies and facilities requires increasing attention to coordination and funding of services. This coordination is essential for the provision of a continuum of services for a high risk population incapable or organizing such services on its own.

There is clearly a need to continue documentation and investigation of the impact of DRGs on the continuum care services for the elderly. Legislators and other designers of health care policy are encouraged to carefully consider (1) the need to support investigators examining the needs for care delivery which have resulted from DRGs, (2) policy to guide development of services and adequate reimbursement of these to include appropriate funding for alternatives to acute care, (3) support for the education of service providers and researchers to develop cost effective alternative care systems for the elderly, (4) including such factors as availability of community and family resources when establishing the basis for DRG reimbursement, and (5) promoting rather than constricting use of Section 2176 medicaid waivers.

What we are experiencing is most likely minor in comparison to the potential long term effects of cost containment policies in their present form. In attempting to make hospitals more cost effective, the burden of care has shifted to community and family care providers who lack the capacity to attend to the complex medical needs of the frail elderly. The net result of cost containment may be lowering hospital expenditure but it is also depriving persons of access to necessary health care.

It may be convenient and politically expedient to regard cost containment efforts in a positive light. If we fail, however, to thoroughly look at those who are carrying the burden of these cost savings, we are obscuring truths that should be acknowledged and acted upon. It is sensible to control the growth of Medicare costs, but it is also prudent to preserve Medicare's social responsibility to provide adequate care for the elderly.

We should continue to try and reach the goal of keeping people at home. We should do so, however, with adequate financial support for the long term care health system and not in such a way as to endanger the patient's life and the breakdown of the their support system.

The CHAIRMAN. Thank you, Mr. Walken. Ms. Brody, please proceed.

STATEMENT OF ELAINE BRODY

Mrs. BRODY. Congressman Roybal and members of the committee. I represent the Philadelphia Geriatrics Center, which is a nonprofit agency that cares for thousands of older people who live on our campus or in their own homes in the community. My testimony is based on our 35 years of experience in serving this population.

At present, public policies are putting extreme pressure on caregiving families who are already overburdened and at risk of mental and/or physical breakdown. Apart from human considerations, such policies ultimately add to the economic cost of health care to the Nation. I am referring, of course, to cost containment efforts with respect to home health care, Medicaid caps, moratoriums on nursing home bed construction and other measures such as the reclassification of nursing home residents to lower levels of care in order to reduce the levels of reimbursement.

All of these things are occurring at the very same time that the prospective payment systems are creating an increased demand for prompt access to services beyond the doors of the acute care hospital. All of this, of course, must be seen in the historical perspective of a system that has focused its long-term care in medical terms when it really is a social problem.

I wish to emphasize that families have proven themselves to be extremely reliable in helping their elderly, often going beyond the call of duty to the point at which their severe burdens affect their own mental and physical health. The myth that families nowadays do not take care of their old people as they did in the so-called good old days is just that, a myth. And sometimes the myth is echoed because it provides a rationale for service cutbacks.

Families are cheered on to redouble their efforts in order to relieve the taxpayer's burden. The fact that has been established without one shred of contradictory evidence over 30 years research is that families, not the Government or social agencies, provide 80 to 90 percent of the health social supportive services needed by the elderly.

Many care-giving adult children, and they are mostly the adult daughters, are in their sixties and seventies. They are close to or even into the aging phase of life themselves, with reduced energy and age-related chronic ailments.

What we have is a situation in which the grandparent's generation is taking care of the great-grandparent generation.

And because the ailments of the old are chronic, families often must provide this care for many years. We have had people in our studies who had been giving care for 20 and more years.

These family efforts, of course, are not without very heavy social and economic costs, as many, many studies have shown consistently. Some of these caregivers experience serious financial or physical stress, most of them experience severe emotional and mental health stress effects, such as depression, anxiety, conflict, frustration, and lower morale. They are restricted to their homes, and the family lifestyles and plans change.

There has also been concern expressed about the possible reduction in family care of the old, and an increased burden on the taxpayer that might occur because so many of the women, who are the principal caregivers to the elderly, are now in the work force.

Let me assure you that this has not happened. The research evidence is consistent here, too. What working women try to do is to do it all. They take care of their families, their elderly parents, and they work, giving up their own free time and leisure activities in order to do so. Recent data from our Philadelphia geriatric studies show that their elderly parents do not receive less care.

To return for one moment to the concern that the Government is paying for services that families should be giving—not only in the research evidence consistent, but I call your attention to the first data that have come out of the 1982 long-term care survey, in which they show that only 4.3 percent of the help needed by older people who need help in their activities of daily living—only 4.3 percent is given by unpaid Government or social agency workers. The rest is given by the family or purchased by the family or older persons.

These family caregivers are the very ones that current policies are urging to do more. They are the ones who are most affected by cutbacks in even the minimal services that are available for the noninstitutionalized elderly.

They are the ones who, after years of taking care of relatives with Alzheimer's disease, are finding nursing homes inaccessible because of cost containment policies that also frustrate efforts to provide quality nursing home care.

I refer you to a recent GAO study, which documented the closing of nursing home doors to the heavy-care medicaid patients, that is, Alzheimer's patients, and I submit for the record a paper on that issue, with the request that it be printed in the hearing record.

These families are the very ones who do not have access to the respite care programs, the day care programs and the other kinds of services that could help them to do what they want to do and what they have been doing.

I respectfully submit that if an irresponsible social policy fails to help the families of disabled older people, the ultimate cost to society will increase. The hidden costs are now becoming visible, the cost in terms of family strain and mental and physical breakdown. These can increase the economic costs to our health and mental health systems, and both the social costs and the economic costs will be transmitted down through the generations.

While I am here, I respectfully request the opportunity to make one final comment. There has been a recent destructive tendency to pit children against the elderly in questions concerning the allocation of resources.

It is tragic that the number of children in poverty has increased, and that deplorable situation must be eliminated. But it is not necessary to increase the number of poor old people in order to do so.

Every scrap of research evidence shows that the well-being of the generations is interlocked. When old people are disadvantaged, their children and their grandchildren are directly affected.

What we do or fail to do for the aged today will provide a model of society's commitment to those children and grandchildren when they become old.

A quarter of a century ago, the World Health Organization pointed out that it is for the sake of the younger generations as well as the elderly that we must see to the latter's well-being.

Thank you very much for the opportunity to share this information with you.

[The prepared statement of Mrs. Brody follows:]

PREPARED STATEMENT OF ELAINE M. BRODY, PHILADELPHIA GERIATRIC CENTER, PHILADELPHIA, PA

My name is Elaine Brody. I am the Director of the Department of Human Services and Associate Director of Research at the Philadelphia Geriatric Center (PGC).

The PGC is a multi-function nonprofit agency that cares for over 1100 older people living on its campus in a variety of arrangements including intermediate and skilled nursing facilities, high-rise apartment buildings with services, converted one-family homes, and a fully accredited geriatric hospital. We also serve thousands of older people who live in their own or their family's households through such programs as in-home services, hospice-home-care, a consultation and diagnostic service, day care, and respite service for families caring for an Alzheimer's patient. My testimony today is based on the PGC's thirty-five years of experience in serving elderly people and their families and on studies about family care of disabled older people carried out by our Gerontological Research Institute.

Current public policies are putting extreme pressure on care-giving families. Many caregivers are already over-burdened and at risk of mental and/or physical breakdown. Apart from human considerations, such policies ultimately add to the economic costs of health care to the nation. The policies I refer to are, of course, cost-containment efforts with respect to services such as home health care, Medicaid caps, moratoriums on nursing home bed construction and reclassification of nursing home residents to lower levels of care in order to reduce reimbursement rates for which they are eligible. All of these restrictions are occurring at the very same time that prospective payment systems are creating an increased demand for services beyond the doors of the acute care hospital.

I wish to emphasize at the outset that families have proven themselves to be extremely reliable in helping their elderly, often going well beyond the call of duty to the point where their severe burdens affect their own mental and physical health. The myth that families nowadays do not take care of their old people as they did in the "good old days" is just that—a myth. The myth survives for a variety of reasons—because people refuse to look at the facts or because of biases, for instance. Sometimes the myth is echoed because it serves a purpose in providing a rationale for service cut-backs—that is, cheering families on to redouble their efforts in order to relieve the taxpayers' burdens. (Parenthetically, it should be pointed out that these caregiving families themselves and the older people they help are the taxpayers.)

The facts that have been established without a shred of contradictory evidence in the course of 30 years of research are as follows:

Families, not the government or social agencies, provide 80-90 percent of the health/social supportive services: medically-related care and home nursing, hands-on personal care, household maintenance, transportation, and shopping. Families respond in emergencies, provide intermittent acute care, and receive the elderly when they are discharged from hospitals and from rehabilitation and convalescent facilities. Families provide the emotional support—the concern, affection, socialization and sense of having someone on whom to rely—that is the form of family help most wanted by the old.

Services from government and agencies do not encourage families to shirk caregiving. Rather, such services complement and supplement those of the family, strengthening the family's capacity to provide care. Moreover, families are extremely modest in their requests for help when it is offered.

In the main, the members of the family who are the principal caregivers to the old are their elderly spouses, helped by adult daughters and to some extent daughters-in-law. But there are nine million widowed older people (most of them women) and their principal caregivers are adult daughters and daughters-in-law. Sons also sustain bonds of affection with their parents and do certain gender-defined tasks (such as financial management), but in general, they do less and are helped by their wives.

Families do not dump older people into institutions. Rather, they exert strenuous efforts to avoid nursing home placement, often exhausting themselves emotionally, physically, and financially before taking that step.

It is not true as the stubborn myth would have it, that "families nowadays do not take care of their old as they did in the past." To the contrary, families nowadays provide more care, more difficult care, over longer periods of time to more older people than ever was the case before. This, despite the fact that family caregivers nowadays have fewer personal resources with which to provide that care and are confronted with more competing demands on their time and energy.

It is the very old who are the most vulnerable to disability. Their caregiving spouses also are in advanced old age, with their capabilities reduced accordingly. Caregiving adult children most often are in their late 40's or 50's, but some are in their 60's and even 70's. They too, are close to or even in the aging phase of life, with reduced energies and age-related chronic ailments. Many are facing widowhood or retirement. It is the grandparent generation that is providing care for the great grandparent generation. In addition, the falling birthrate has resulted in today's older people having fewer adult children to share their care when need be. And because the ailments of the old are chronic, families often must provide care for many years.

Family efforts are not without heavy social and economic costs, as many studies have shown. Some family caregivers experience financial strain and some suffer from stress-related physical ailments. Majorities experience emotional/mental health symptoms such as depression, anxiety, conflict, frustration, and lowered morale. These negative effects result from the restrictions on their time and freedom, difficulties in setting priorities from among the multiple and competing demands on their time and energy, and from interference with their life-styles, privacy, social and recreational activities, vacations, future plans, and income.

Concern has been expressed about the possible reduction in family care of the old and increased burden on the taxpayer that might occur because many women in the parent care years are now in the work force. Let me assure you that this has not happened. Again, the research evidence is consistent. The vast majority of working women try to "do it all"—they take care of their families, their elderly parents and work, giving up their own free time and leisure activities to do so. Moreover, most women work because they and their families need the money.

In a recent PGC research study, we found that many adult daughters, whether or not they worked, and "caregiving careers." They had helped care for their fathers and other elderly family members in the past, were caring for more than one old person at the time of the study, and most of them still had their own children in their households.

In the same study, we found that some working daughters, after years of arduous caregiving to disabled elderly parents in addition to doing paid work, quit their jobs to take care of the older people. Some working women had cut back on their working hours or were considering quitting. Both of those groups of daughters had extremely dependent parents, many with Alzheimer's disease, whom they had been helping for long periods of time with the result that their health had suffered. Those who had left their jobs had extremely low family incomes (40 percent of them under $15,000 a year). Some of the working women lost time from their jobs and had passed up opportunities for advancement.

A most important finding from our study is that the parents of the working women were receiving just as much help as the parents of the nonworking women. The working women themselves continued to give their parents as much emotional support, help with shopping and transportation, household maintenance and coordination of services. When the working women needed someone to be at home with the parent during working hours, most of that help was purchased, not provided free of charge by the government or social agencies. To underline—only a small fraction of the services received by older people are paid for by government. This was found not only in our study, but by the classic GAO study of the Cleveland area and was recently confirmed by a HCFA report on national data collected by the 1982 Long Term Care Survey.

These family caregivers—elderly husbands and wives and overburdened adult children—are the very ones current policies are now urging to do more. These are the ones who are most affected by cutbacks in even the minimal services that are available for those who care for the noninstitutionalized elderly. These are the ones who, after years of taking care of relatives with Alzheimer's Disease, are finding nursing homes inaccessible because of cost-constainment policies that also frustrate efforts to provide quality nursing home care. A recent GAO report has documented the closing of nursing home doors to "heavy care" Medicaid patients. (I submit for the record a paper my colleagues and I wrote on that issue which appeared in the American Journal of Public Health.) These families are the ones who, except for a sprinkling of demonstration projects, do not have access to respite care programs, day care programs, and other services that could help them to do what they want to do and have been doing.

I respectfully submit that if an irresponsible social policy fails to help the families of disabled older people (including families of those who have Alzheimer's disease), the ultimate costs to society will increase. The hidden costs now becoming visible—costs in terms of family strain and mental or physical breakdown—can increase the economic costs to our health and mental health systems. Both the social costs and the economic costs will be transmitted down through the generations.

One final comment—

Recently there has been a destructive tendency to pit children against the elderly in questions concerning the allocation of resources. It is tragic that the number of children in poverty has increased. That deplorable situation must be eliminated.

But it is not necessary to increase the number of poor old people in order to do so. The well-being of the generations is interlocked. When old people are poor or otherwise disadvantaged, their children and grandchildren are directly affected. What we do (or fail to do) for the aged today, will provide a model of society's commitment to those children and grandchildren when they become old. A quarter of a century ago, the World Health Organization pointed out that it is for the sake of the younger generations as well as the current generation of elderly that we must see to the latter's well-being.

When Benjamin Spock was campaigning for the passage of Medicare, someone asked him why he was doing so. He replied that he loved children so much that he wanted to be certain they would receive good care when they become old.

Thank you for the opportunity to share this information with you.

Commentary

Senile Dementia: Public Policy and Adequate Institutional Care

Elaine M. Brody, M. Powell Lawton, PhD, and Bernard Liebowitz

Abstract: Increasing costs of institutional care for the aged have occasioned a variety of government cost containment measures. People with senile dementia of the Alzheimer's type (SDAT) will be the principal group to suffer from cutbacks. SDAT patients are usually eligible for Intermediate Care Facilities (ICFs), rather than Skilled Nursing Facilities (SNFs) and therefore for lower reimbursement. Because such patients require heavy care and are the ones most likely to be Medicaid-dependent nursing homes are being provided with incentives to prevent admissions. At the same time, community services to aid overburdened caregivers are grossly inadequate. Costs to other parts of the health systems are increased by backups in acute hospitals when nursing home beds cannot be found. SDAT and Medicaid eligibility are the principal causes of such "administratively necessary" backup days, but in the main Diagnostic Related Groups (DRGs) may close even that temporary resource. Thus, virtually all avenues of care are shrinking for those who need them most. (*Am J Public Health* 1984; 74:1381–1383.)

The increasing costs of institutional care for the aged have occasioned a variety of cost-containment measures. This commentary considers the potential effects of such cost-containment measures on a particular group of long-term care patients: those suffering from senile dementia of the Alzheimer's type (SDAT).

Alzheimer's Disease as a Social Problem

The increase in the population of older people who suffer from SDAT and related disorders is due to the dramatic increase in the number and proportion of older people and an even more rapid increase in the oldest portion of this population. Between now and the year 2000, the number of people ages 65–74 will increase by 23 per cent, those ages 75–84 will increase by 57 per cent, and those age 85 and over will almost double.[1] Since prevalence rates of SDAT rise from about 2 per cent in those who are age 65–70 to 22 per cent in those age 80 or over, the most rapid increase will continue to be among those people who are most vulnerable to Alzheimer's disease—the very old.

SDAT patients are at high risk of nursing home admission. Various studies identify characteristics predictive of admission as dependency in personal care functions,[2] mental disorder and senility with psychosis, disorientation, and inability to make decisions. The likelihood of people with such diagnoses or symptoms being institutionalized is greater when they are very old, unmarried, or without informal social supports.[3]

A minimum of 60 per cent of nursing home residents of such facilities have SDAT compared with about 7 per cent of the total elderly population.[4] The 1977 National Nursing Home Survey found almost 60 per cent of residents to have chronic brain syndrome or senility without psychosis.[2]

About half of the nursing home patients admitted in the course of a year stay less than three months, having been admitted for terminal care or for short-term rehabilitation or convalescence.[2] SDAT patients are unlikely to be discharged, however, and undoubtedly predominate among long-stay patients.[2] Those patients who are long-stayers in nursing homes are most often supported by Medicaid.[3] The proportion of residents whose primary source of payment is Medicaid rises as the length of stay increases,[3] reflecting the spend-down process. SDAT patients, then, are the ones who constitute the majority of long-stay patients and the ones most likely to be Medicaid dependent.

SDAT presents unique caregiving problems and is probably the most socially disruptive of all ailments because of its symptoms: impaired memory and disorientation; poor judgment; inability to communicated rationally; inappropriate, unpredictable, embarrassing, or dangerous behavior; incontinence; wandering; and/or the need for constant surveillance. Some caregivers are unable to leave their homes for weeks or months at a time and receive little or no gratifying "feedback" from the recipients of their care. It is thus critical for nursing home beds to be available for the use of families whose caregiving capacities have been exceeded.

An additional element of strain is due to the characteristics of the family caregivers themselves. Because those afflicted with SDAT are generally the *very* old, their caregivers are most often either elderly themselves (when the patient is a spouse or a sibling) or in late middle age, with their energies and strength depleted accordingly. Caregiving spouses are the most likely relatives to provide care for long periods of time.[5] Periodic surveys we have made at the Philadelphia Geriatric Center's nursing facility indicate that SDAT is the diagnosis for 70 per cent to 85 per cent of all married residents whose spouses are not in the nursing home.

In the overwhelming majority of cases, nursing home placement occurs only after responsible family caregivers have endured prolonged, unrelenting strain (often for years), and no longer have the capacity to continue their caregiving efforts. The current mushrooming of self-help groups of family caregivers reflects their need for mutual emotional support.

The care needs that place heavy demands on family caregivers continue after institutionalization and make the heaviest demands on nursing home staff. For example, in a

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Address reprint requests to Elaine M. Brody, Director, Department of Human Services and Senior Researcher, Philadelphia Geriatric Center, 5301 Old York Road, Philadelphia, PA 19141. Dr. Lawton is Director of Behavioral Research, and Mr. Liebowitz is Executive Vice President, both at the Center. This paper, submitted to the Journal January 17, 1984, was revised and accepted for publication July 11, 1984.

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direct-observational study of caregiving in the separate treatment areas of one institution, residents in an SDAT unit received considerably more nursing care and the area was more densely staffed than those areas serving either the less-impaired or those whose impairments were primarily physical.*

Apart from the sheer time demands on staff for personal care and behavioral problems, these patients require highly skilled and sensitive attention because they cannot articulate their needs, the symptoms that signal illness, or even negative reactions to drugs.

Policy Background

Until recently, little attention was paid to the specific problems of patients with SDAT. During the deinstitutionalization wave of the 1960s (spurred by Public Laws 88-164 and 89-105, the Mental Health and Retardation Acts of 1963 and 1965, respectively), older people were being discharged from mental hospitals in large numbers and their admissions were discouraged. The SDAT patient was severely affected by such policies, being deemed not "mentally ill", inaccessible to active treatment, and therefore inappropriate for mental health facilities. These patients also tended to be denied admission to homes for the aged and nursing homes as inappropriate and too difficult to care for. However, admission criteria in long-stay nursing facilities were relaxed slowly as the number of both SDAT patients and long-term care beds increased.

Between 1960 and 1970, the nursing home/home for the aged population increased by 105 per cent from 388,000 to 795,800 people.[7] By 1977, the National Nursing Home Survey found a total of 1.3 million people in nursing homes, of whom 1.1 million were age 65 or over.[2] In 1980, there were 1.5 million nursing home beds and 1.4 million residents in those facilities.[8]

The costs of nursing home care have been rising, propelled by inflation as well as the sheer number of people in need of such care. In 1982, nursing home care cost more than $27 billion of which Medicaid paid more than half.[9] From 50 per cent to 78 per cent of the States' Medicaid costs are met by the federal government and those costs have been increasing at a rate of about 14.5 per cent annually.[3]

Although there is enormous variability among the states in eligibility criteria, services provided, and reimbursement levels, all states offer the mandatory skilled nursing facility (SNF) and the optional intermediate care facility (ICF) levels of care. Public Law 92-603 dictates that there be a common definition of the level of care in SNFs covered by Medicare and Medicaid. The wisdom of this requirement is not evident, considering that Medicare criteria were developed for post-hospital short-term care, while Medicaid covers long-term care. Virtually all the states reimburse SNFs at a higher rate than ICFs, with regulations for SNFs calling for richer staffing patterns. In 1977, SNFs had about 52 FTE* per 100 beds versus 40.7 FTE per 100 beds in ICFs.[2]

Cost-containment efforts were given impetus by reduction in the federal contribution to Medicaid as passed in the 1981 Omnibus Reconciliation Act (Public Law 96-499, section 962), as well as by fiscal pressures on state budgets. In 1982, at least 30 states reduced or limited Medicaid benefits, eligibility, or provider reimbursement.[9] Such restrictions on the nursing home bed supply and on reimbursement are occurring despite indications that nursing home occupancy rates are high nationally and the annual growth rate in bed supply has not kept pace with the annual growth rate in the number of heaviest users of nursing home care (those age 85 and older) in recent years.[3]

Impact of Current Policies

The presence of SDAT imposes major caregiving demands upon institutions as well as upon family caregivers in a household. In a national situation where institutional beds are limited and public reimbursement levels receding, there is good reason to be concerned about the SDAT person's access to nursing facilities and, if accepted, quality of care received. High occupancy rates make it possible for nursing homes to select private-pay patients and lighter care Medicaid patients.

Another direct result of cost-containment measures is the inappropriate lowering of the level of care for those with SDAT who are already residents. Reimbursement levels speak to the number of nursing and other staff and therefore to the quality of the care that is provided. To quote the recent report of the General Accounting Office (GAO), "The objectives of assuring access and providing quality care for Medicaid patients are, however, often in conflict with a third major goal of reimbursement policy—controlling costs."[9] The states have been given greater flexibility in adjusting their rates but the quality standards on which the "reasonable and adequate" rates required are to be based have not been spelled out.

People with SDAT have higher age-adjusted mortality rates than patients encountered in psychiatric settings with other diagnoses.[10,11] Although no research findings speak to the issue, it is possible that the behavioral deficits make these people more subject to accidents or personal neglect. SDAT patients in institutions may require extra care and surveillance as a preventive measure against excess mortality.

A rationale often advanced for restricting the number of nursing home beds is that community care is more desirable and less costly. However, people with SDAT are the least likely group to be maintained by community "alternative" services, since they require round-the-clock care. As the Cleveland GAO Study and others have shown, the cost of community care for severely impaired old people is higher than that of institutional care. Moreover, home health services are in very short supply, and there would still be a shortage of nursing home beds even if such noninstitutional services were to be expanded.[3]

When SDAT patients cannot obtain care, the burden falls on their exhausted, over-strained family caregivers who themselves are at risk of experiencing a negative impact on their mental and physical health. Although temporary relief, such as day care or other respite care, exists in some form in some places, such services are not universally or adequately available and there is limited regular public or private funding for their consistent support.[11] Moreover, many old people in need of nursing home care do not have family supports on which to rely; the vast majority of those in nursing homes are not currently married and they have far fewer adult children than the non-institutionalized.[14] Ten per cent of nursing home residents are without anyone at all to name "next-of-kin."[15]

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*Lawton MP, Brody EM, Falconer MC: Staffing patterns for demented and non-demented residents of nursing homes. Paper submitted for publication 1984.

From the economic perspective, it should be noted that costs to other parts of the health system are often increased when nursing home beds are not available. The report of the Office of the Inspector General indicates that some nursing homes discharge "undesirable" Medicaid patients to high-cost hospital beds.[15] In addition, such patients back up in hospitals because nursing home beds cannot be found.

Although there are few data on the cost of keeping patients in hospitals because nursing home beds are unavailable, it has been estimated that there may be between one million and 9.2 million such unnecessary hospital days annually.[3] One analyst states that the Hospital Insurance Trust Fund spends more than a billion dollars a year in acute hospital fees for those waiting to enter nursing homes.[16] SDAT patients undoubtedly account for a significant portion of that cost since the longest-staying backup patients tend to be Medicaid-eligible, to have behavioral problems, to be incontinent and disoriented, and to suffer from addictive illnesses.[5] One survey of hospital discharge planners found that hospital patients for whom nursing home care is most likely to be deemed necessary are mentally confused, lack family supports or require care beyond the family's capacity, and are unable to be fully self-caring.[17] Medicaid eligibility was cited by 98 per cent of the hospitals in the survey as a problem in placement. The GAO report concludes that nursing home cost containment measures could increase current problems by intensifying existing incentives to use the health care system inefficiently.[3]

The advent of prospective payment systems and Diagnostic Related Groups (DRG) which limit reimbursement for hospital care provide powerful incentives to acute care hospitals to prevent back-up of those patients characterized by the symptoms of SDAT.[3,18] The problem is therefore being compounded, with all avenues of care—temporary and long-term—shrinking.

In short, the SDAT patient and family are in a classic Catch-22 bind. Because of the scarcity of community support services (such as respite care, day care, and in-home services), they get virtually no help in community living. They often cannot obtain institutional care, and in the main, will not be able to remain in hospitals beyond their need for acute care to the same extent as in the past. Their current situation is reminiscent of their no-care situation during the late 1960s and 1970s.

It is an inescapable conclusion that nursing home care for those with SDAT *should* cost more if they are to be cared for appropriately. Exactly the opposite is happening, since disincentives to the nursing homes to admit such patients, combined with disincentives to acute care hospitals to permit back-up, result in reimbursement being lower for that group and the quality of their care suffers. The social cost to family caregivers is heavy; the economic cost of *their* resultant need for health care has not been calculated.

The failure of the present care system to provide adequately for SDAT patients needs to be made evident to those responsible for making public policy.

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The CHAIRMAN. Thank you, Mrs. Brody.
Mr. Yovanovich.

STATEMENT OF STEPHEN YOVANOVICH

Mr. YOVANOVICH. Mr. Chairman, and members of the committee, my name is Stephen Yovanovich, and I am president and chief executive officer of the Visiting Nurses Association of Butler County, located in Butler, PA. I am presenting this testimony on behalf of the National Association for Home Care and the American Federation of Home Health Agencies. I would like to thank this committee for providing a forum in which we can explore the elderly's access to home and community-based health care, and the impact of recent legislative and regulatory changes on such services.

Home health care is a humane and cost-effective alternative to institutionalization for elderly and disabled Americans who prefer to remain in their own homes with dignity and independence. The home health benefit is growing as the population ages, and Federal policy, such as prospective payment for hospitals, encourages noninstitutional care.

Despite strong support from Congress and the public, the inevitable growth of home health care is being used as justification by the Health Care Financing Administration for excessive strictness in developing policies to govern the benefit.

As a result of restrictive reimbursement policies developed several years ago, the skilled nursing benefit is no longer available to many Medicare beneficiaries.

Now, HCFA has developed a series of policies to achieve shortsighted savings in the home health benefit that will restrict the availability of home health services to beneficiaries. These policies include a proposal to effectively eliminate waiver of liability, a restructuring of cost limits, and a restrictive definition of intermittent care.

Mr. Chairman, your House Select Committee on Aging held a hearing this past February which demonstrated the impact of prospective payment for hospitals. Home health agencies are now seeing much sicker patients, requiring much more complex care and visits of longer duration, as prospective payment shifts the burden of caring for Medicare beneficiaries to home health care.

But in recent months, we have seen a sharp increase in home health denials on cases that clearly meet Medicare coverage guidelines.

It appears that HCFA is attempting to create a climate of uncertainty for home health agencies in the hope that they will cut back on services rather than risk payment denials.

This is a shortsighted attempt to achieve savings. Home health agencies are cost-reimbursed and cannot provide care for very long if they are not compensated for the services that they give.

We believe HCFA's policies will result in greater cost down the road for institutional care for patients unable to receive home health services, and it will have a great cost in human terms for patients unable to obtain care.

Fiscal intermediaries appear to be under duress to deny a certain percentage of cases, for example, to return at least $5 for every one they receive for medical and cost report review.

Mr. Chairman, with your permission, I would like to submit for the record a copy of the guidelines that appear in HCFA's Contractor Performance Evaluation Program which outline this ratio for medical and cost review functions.

This arbitrary requirement may account for the 32.4-percent reversal of denials by intermediaries themselves when there is reconsideration of the case. It is worth noting that the fiscal intermediaries suffer no penalty for their mistakes, although requiring home health agencies to perform perfectly. It appears that the fiscal intermediaries are unable to achieve that same quality.

A concerned coalition of part A and part B providers, consumers, legal and senior citizens' organizations, formed a coalition out of concern for access of beneficiaries to Medicare services.

This broad-based group was first brought together in response to HCFA's proposal to eliminate, in effect, the waiver of liability protection for hospitals, skilled nursing facilities and home health agencies.

With your permission, we wish to submit for the record 50 sample cases of home health services denied in whole or in part. These come from a survey conducted to obtain cases to illustrate the impact loss of waiver would have on Medicare beneficiaries and home health providers.

If the favorable waiver presumption is lost, patients like these would probably be unable to receive the services that their physicians have ordered for them.

These cases are intended to illustrate specifically the waiver issue, but they indicate a larger problem, that there are disabled and elderly Americans sick enough to be hospitalized and sick enough to, in fact, die, but unable to receive the health care they need between hospitalization and death.

It is a shame that our fellow citizens are put in a position of scrambling after health care or else going without care in their final days.

Mr. Chairman, I will pass over several case histories that I was to present. As you know, in our written testimony, we have submitted 50 cases that, I think, explain quite clearly the dilemma that home health agencies are placed in.

If patients like those we have submitted to you cannot get home health care, then who can? Beneficiaries as old and sick and debilitated as those that we presented to you are not in a position to mount an effective appeal against the massive Federal bureaucracy.

HCFA policy now prevents providers from representing beneficiaries in the appeals process. Intermediaries are fairly safe making denials in cases where there is no one left to fight.

The Medicare Program exists for the benefit of elderly and disabled persons. Those who run the Medicare Program should demonstrate the same passion for access to care and quality of care as they do for making cuts in the program.

Mr. Chairman, to help preserve the Medicare home health benefit for Medicare beneficiaries, for members of our own families, and for ourselves some day, we urge Congress to preserve the current waiver of liability protections for providers and for the beneficiaries, to maintain the current home health cost cap structure with limits at the 75 percentile and an aggregate rather than per-discipline method for the application of cost cap reimbursement for home health agencies, and the enactment of legislation to define intermittent care statutorily.

Thank you for this opportunity to present our testimony here today.

[The prepared statement and exhibits submitted by Mr. Yovanovich follow:]

Prepared Statement of Stephen G. Yovanovich, President and Chief Executive Officer, Visitng Nurses Association of Butler County, Inc., Butler, PA, on Behalf of the National Association for Home Care, and American Federation of Home Health Agencies

Mr. Chairman and Members of the Committee: My name is Stephen Yovanovich. I am President and Chief Executive Officer of the Visiting Nurses Association of Butler County, Inc., located in Butler, Pennsylvania. I am presenting this testimony on behalf of the National Association for Home Care (NAHC) and the American Federation of Home Health Agencies (AFHHA). I would like to thank this Committee for providing a forum in which we can explore the elderly's access to home and community-based health care, and the impact of recent legislative and regulatory changes on such services.

At the time of increasing concern about the expenditure of Federal money on health services, home health care is a humane and cost-effective alternative to institutionalization for elderly and disabled Americans. The home health benefit is inevitably growing as the population ages; as technology advances and home health agencies develop the ability to care for more and more complex cases; as more patients and physicians become aware of its benefits; and as Federal policies, such as prospective payment for hospitals, encourage the use of non-institutional services. Clearly, the elderly of this country desire expanded home care services. In a recent Gallup Poll conducted for the American Association for Retired Persons, home care was preferred to institutional care by about 80 percent of AARP's membership.

Despite strong Congressional and public support, we find the greater use of home care services cited as justification by the Health Care Financing Administration (HCFA) for developing excessively stringent regulations and policies to govern the home health program. We believe that it makes no sense to pursue policies which enourage deinstitutionalization while hindering the ability of home health agencies to deliver the medically necessary services patients require upon discharge. We believe HCFA's actions are in direct contradiction to Congress' historic action to increase access to home care.

As a result of restrictive reimbursement policies developed several years ago by HCFA, the skilled nursing benefit is no longer available to many Medicare beneficiaries in need of nursing home care. Now HCFA has developed a series of policies to realize short-sighted savings in the home health benefit which will only lead to higher institutional costs down the road for those patients unable to receive the less costly home health services.

In recent months, we have witnessed a sharp increase in the denial of home health claims. It appears that HCFA is attempting to create a climate of uncertainty for HHA's in the hope that, rather than risk disallowances, HAA's will arbitrarily cut back on the frequency of services, evern though good medical practice would suggest the visits *should* be made. The pressure to increase claims denials comes from HCFA's FY'85 contractual mandate to fiscal intermediaries to produce *at least* a $5 return for every dollar expended in the medical review portion of the intermediaries budget. HCFA simultaneously has mandated that intermediaries subject at least 37.5 percent of all claims to medical review in fiscal year 1985. Both thresholds are expected to increase in fiscal year 1986.

We have a number of cases, illustrated on the attached chart, which demonstrate seriously ill patients who were judged by the intermediary not to be sick enough to get home health services their physicians ordered. Many of these beneficiaries were sick enough to be hospitalized and sick enough to die. But fiscal intermediaries determined that, in the interim between hospitalization and death, they were not entitled to the medical care their physicians determined they needed.

Fiscal intermediaries appear to be under duress to deny a certain percentage of the cases they review. Intermediaries can safely deny visits in cases such as those we illustrate on this chart. HCFA policy now precludes providers from representing the beneficiary in the appeals process. But for beneficiaries as old, sick, debilitated, and alone as many of them are, mounting an effective appeal against a massive government bureaucracy is out of the question. The 32.4 percent reversal of home health denials by the intermediaries themselves at the reconsideration level indicates a high rate of erroneous denials. Fiscal intermediaries, however, suffer no penalty for their own mistakes.

In addition to an upsurge in denials, over the last two years we have witnessed a series of actions on the part of HCFA which will reduce the ability of home health agencies to deliver services to elderly and disabled Americans. Acting with little or no consultation with affected providers and consumers, HCFA has:

Proposed regulations which would have the effect of eliminating waiver of liability protection for home health agencies;

Acted to reduce fiscal intermediaries serving freestanding home health providers from 47 to 10;

Proposed restructuring of the home health cost limits;

Sought imposition of a $4.80 copayment on all home health visits after the twentieth;

Attempted to change the rules to redefine "homebound" and "intermittent" in order to restrict the availability of home health services; and

Developed a massive new "minimum" data elements reporting requirement for all home health agencies.

WAIVER OF LIABILITY

HCFA issued proposed regulations in the Federal Register on February 12, 1985, to eliminate, in effect, waiver of liability protection for HHAs, SNFs, and hospitals. The comment period closed March 14, 1985.

Under the waiver policy currently in effect, HHA's with a quarterly denial rate of 2.5 or less are paid for denied services if it is determined that the HHA did not know or could not have reasonably known that the services were not reasonable and necessary, or constituted custodial care.

Congress instituted the current waiver presumption in 1972 to protect both Medicare patients whose care falls into an area of subjective judgment, and Medicare providers which need the protection in order to render services falling into the grey areas. The waiver presumption also serves to protect the beneficiary and the provider by providing a minimal "cushion" from what is also a subjective decision by an individual during the intermediary review process.

In the wake of publication of this proposed rule, associations representing HHAs and other Medicare providers, legal, consumer, and senior citizens groups formed a coalition to inform HCFA and Congress of the devastating effect loss of waiver would have on Medicare beneficiaries and providers.

The proposal is temporarily on hold as a HCFA task force considers its implications. Revised or final regulations may be issued later this year. We urge that this regulation be withdrawn altogether.

A preliminary report by the GAO to Senator Heinz, Chairman of the Senate Special Committee on Aging, indicates patients are being discharged from hospitals in a poorer state of health. Sicker patients will require more visits than those with the same diagnoses in the past. Loss of waiver of liability will make it difficult for some of these beneficiaries to receive home health services.

The cases which we have attached illustrate patients whose care was denied, in whole or part, but which was covered under waiver of liability. If the favorable waiver presumption is lost, presumably in the future these types of patients would not be able to receive the home health services ordered by their physicians.

Home health agencies are cost reimbursed. They have limited capital resources to fund visits not covered under waiver of liability. Waiver allows access to care for patients whose care falls into the area of subjective judgment.

The case-by-case approach HCFA now proposes to implement will put an inordinate burden on many elderly and infirm beneficiaries who, in effect, will have to appeal denial decisions and prove the visits in question should be covered under waiver.

The performance of intermediaries makes waiver protection essential. HCFA now proposes to hold HHA's to a 100% standard of accuracy, while acknowledging a 32.4% rate of reversal on appeal for HHA denials. HHA's often receive inconsistent and unclear directives from intermediaries. The majority of HHA's will be transferred to new intermediaries shortly, exacerbating the denial problem for agencies trying to adapt to the policies of a new intermediary.

COST LIMITS

As you are no doubt aware, both the House and Senate have approved their respective budget proposals. Each includes a freeze in reimbursement for all Medicare providers. This action, in and of itself, does not allow home health agencies to adjust to the projected 5.6 percent increase in the market basket index. However, in addition to this proposal, the Health Care Financing Administration has undertaken its own budgetary process—despite the fact that it is not within their scope of jurisdiction to do so. By its own admission, HCFA acknowledges that this proposal "will have a major impact on the HHA industry", "would clearly have a significant economic impact on a substantial number of HHA's", and that the proposal would "affect 70 percent of the industry".

HCFA issued a May 14th proposal in the Federal Register, which abandons the current method of calculating the cost limits for reimbursements to home health agencies on behalf of beneficiaries who require and are entitled to home health care services. For the past five years, home health agencies have operated under a system which sets the reimbursement limit on each visit at the 75th percentile of overall national agency costs. The fact that the rates are currently calculated in the aggregate allows an agency the flexibility to provide certain kinds of care which exceed the cost limit cap. High cost services (i.e., Physical Therapy) are offset by being under the limit in other services. The ability to aggregate allows an agency to stay beneath the cost limit overall, while providing the full integrated range of care.

The HCFA proposal would instead set the cap at 20 percent above the average visit cost for each individual discipline and eliminate use of "aggregation". We have serious reservations about the methodology used to establish the new rates under this method, and question the projected lost savings. However, we are unable to specifically comment because our requests for pertinent information on the data used to calculate the new cost limits have not been responded to. We specifically requested this information on two occasions, but have received no response. A number of Members of Congress have also written to express their concerns, but have received only a cursory response—if that.

HCFA has also violated the spirit, if not the letter, of the law. The Administrative Procedures Act requires an agency to provide adequate time for impacted groups and individuals to respond to any proposed change in regulations. HCFA allowed for a comment period of 30 days. This is wholely unreasonable. We wrote, our membership wrote, and Members of Congress wrote to ask that another 30 day period be allowed for comments. These requests have been ignored.

I must mention that HCFA issued the final notice in the July 5th Federal Register in blatant disregard of a substantial number of requests from Members of Congress to delay finalization until Congress had completed its Budget and Reconciliation Act. With so little advance notice, many agencies will be placed in a chaotic state. One fourth of all home health agencies have cost report years and fiscal years beginning on July 1 (the date of implementation). They have already had their budgets approved for months, and hired staff accordingly. Another one half of the agencies have new years beginning October 1, and most of these have already had their Boards approve the budgets. With so little advance warning, many agencies may be forced to reduce staff and services, or even close their doors. Particularly, such high cost services will be in jeopardy in terms of availability to beneficiaries.

Without Congressional intervention, we fear the result of this proposal will be to decrease the quantity of services available, but also may jeopardize the quality of care rendered to elderly and disabled beneficiaries.

FISCAL INTERMEDIARY REASSIGNMENT

HCFA issued proposed regulations in the Federal Register on April 10, 1985, reducing to ten the number of fiscal intermediaries processing home health claims for freestanding home health agencies. The comment period closed June 10, 1985. It appears that HCFA plans to implement the reassignment of HHA's sometime between October 1, 1985 and February 1, 1986.

Reduction to no more than 10 intermediaries by July 1, 1987, was mandated by the Deficit Reduction Act of 1984. Congress enacted this provision to assure greater uniformity in interpretation of Medicare home health policy throughout the country. We have supported this move to ensure greater consistency in the application of coverage and reimbursement policy; however, we assumed HCFA would employ a more rational basis in the selection process. In the proposed regulation, HCFA mentions a number of criteria that it considered in selecting the 10 intermediaries; however, it gave no indication of how those selected rated in each of these areas or how their performance compared to intermediaries not selected.

HCFA states that a major criterion in selecting intermediaries is the ability to process bills electronically; however, four of the ten intermediaries apparently do not currently have this capability, making it difficult to comprehend why they were selected. HCFA states a desire to minimize transition problems, but it has selected several intermediaries which currently service only a relative handful of HHA's.

It is not clear where these small intermediaries will get the personnel to process claims. HCFA has not stated any policy on subcontracting. If they have to subcontract most functions back to the old intermediaries, it makes no sense to select them in the first place. If the ten intermediaries are going to subcontract audit, appeals, or onsite review functions to other intermediaries, it will lead to more of the same type of inconsistencies which Congress is trying to correct.

Contrary to Congressional intent, HCFA's proposed April 10th restructuring applies only to freestanding agencies and not to "provider-based" agencies (i.e., those which are hospital, nursing home, or rehabilitation facility-based).

We believe that HCFA should issue revised proposed regulations publishing the scores and rankings of the 10 tentative intermediaries, with an explanation of what actual considerations were used in the selection process, and applying them to all types of home health agencies.

COINSURANCE FOR HOME HEALTH CARE

Again this year, the Administration's budget proposal included a provision which would have imposed a co-payment on Medicare beneficiaries equal to $4.80 per visit after the 20th home health visit in a calendar year. Both provider and beneficiary groups strenuously opposed this proposal for a number of reasons.

The proposal would unfairly increase the burden on Medicare beneficiaries. Medicare beneficiaries are already required to make significant out-of-pocket expenditures to finance their own health care. Imposing a new co-payment for home health visits would increase the financial burden on beneficiaries and would result in patients going without needed home care or in unnecessary hospitalizations.

In addition, this proposal is totally contradictory to the goal of discouraging excessive utilization of institutional placement. Congress has taken several specific actions toward achieving this goal in the past few years, and we would be penny-wise and pound-foolish to reverse this trend. For example, the result of discouraging home care by the imposition of coinsurance will certainly be that those who are being discharged early due to the DRG system will fail to adequately recuperate and will simply return to the hospital or nursing home.

Far from saving millions of dollars, coinsurance would result in increased costs to Medicare. Home health agencies and/or the government would be put in the position of collecting coinsurance from the elderly. The administrative costs in doing so would be enormous, and would necessarily be passed along to Medicare. Also, as HCFA Administrator Dr. Carolyne Davis pointed out in her April 1st testimony before the Ways and Means Subcommittee, Medicare would have to cover the cost of non-paying beneficiaries by reimbursing agencies under the bad debt allowance. This will more than offset any savings which are anticipated from the implementation of coinsurance.

Some have expressed a concern about the overutilization of home care benefits and believe coinsurance will curtail this misuse. We reject this premise, and in fact the government's own statistics show 4.9 million Americans going without the home care or supportive services they need. The Heritage Foundation summed up the advantages of increased utilization of home care in its December 1984 report, Mandate for Leadership: "widening use of home health programs . . . would reduce cost considerably." Simply stated, the increased out of pocket costs will constitute a real barrier to quality care for those who simply cannot afford to pay.

Fortunately, both the House and Senate, in their respective Budget Resolutions, rejected the proposal. We remain hopeful that the House Ways and Means Committee and the Senate Finance Committee will also reject this proposal in their reconciliation legislation.

INTERMITTENT CARE

We are particularly concerned that existing Medicare home health benefits is being unjustifiably limited, contrary to Congressional intent, by the Health Care Financing Administration (HCFA) and its contract intermediaries. This is being done by restrictive and inconsistent interpretations of the term "intermittent care" as defined in the Medicare statute which determines the nature and frequency of home care to nearly 2 million elderly, infirm, and disabled beneficiaries.

In creating the Medicare home care benefit, Congress stated that covered care was to be "intermittent" but did not specifically define what constituted "intermittent care." The Health Care Financing Administration issued guidelines on intermittent care to the fiscal intermediaries who process claims for home care providers. Under these guidelines, intermittent care would include daily care for a 2-3 week period, and thereafter under "exceptional circumstances." The major problem that has occurred with regard to these guidelines is the varying and inconsistent interpretations by fiscal intermediaries as to what constitutes intermittent care. Although Medicare is a national benefit, a Medicare beneficiary living in California can receive a substantially greater home care benefit than one living in Wisconsin. Some intermediaries consider "daily" to mean 7 days a week, but others consider it to mean 5 or even as little as 3 days a week. Some intermediaries view the 2-3 week initial period as a guideline and consider extensions of this period on a case-by-case basis; others see 2-3 weeks as a rigid cut-off point, regardless of medical reasonableness and necessity as determined by a physician. An example of the many types of problems this has created is illustrated in Michigan. In the same city, two home health agencies operate. Each is served by a different intermediary, because one of the agencies is a chain served by a central intermediary. One intermediary is liberal, the other restrictive. So, depending on which agency a patient uses, he/she will get more/less coverage.

The implications of these varying and inconsistent interpretations of "intermittent care" are that there are thousands of cases where patients who have been authorized by physicians as medically needing home care have been denied home care outright, or have had home care severely limited.

The implementation of the hospital prospective payment plan has exacerbated the already acute "intermittent care" problem, as documented by the GAO Report released this year to the Senate Special Committee on Aging previously mentioned in this testmony.

Senator John Heinz and Congressman Henry Waxman intorduced legislation last year which would have denied "intermittent care" statutorily. This legislation, unsuccessful in the last Congress, has been reintroduced in this Congress (S.778/H.R.2371). Without the aid of such legislation, providers are "subject to the whims of fiscal intermediaries" in making key coverage decisions.

HCFA FORMS 443/444

In December 1984, HCFA issued Transmittal 158 to home health agencies requiring them to submit new forms (443 and 444) as a precondition of their receiving payment from Medicare. These forms were to be implemented on January 1, 1985. Home health agencies had no prior notice that these new forms would be issued. Nor were industry representatives consulted as to the issuance despite assurances by HCFA staff that open channels of communication could be expected. With Congressional intervention, the implementation date was postponed to February 15, 1985.

The new forms had serious flaws both in terms of design and content. They were never field tested. They would not fit into a standard typewriter. Computerized forms would not have been available until after the February 15 deadline, nor would computer specifications be available to the computer companies which help prepare billings for home health agencies. Further, the new forms substantially overlapped another computerized billing form (UB-82) mandated effective October 1, 1985. HCFA acknowledged that the new forms were problematic and agreed to redesign them before they were printed new in June 1985. However, the agency refused to delay the February 15 implementation date.

Through substantial industry efforts and the subsequent intervention of Congress, HCFA eventually delayed the implementation of these forms to September 1, 1985 and worked with home health providers and industry representatives in redesigning the forms now known as HCFA Forms 485-488. Had HCFA worked with providers prior to issuing these forms, Congressional involvement and significant provider concern could have been averted.

CONCLUSION

In light of the problems I have discussed here, we urge the Congress to take the following action:

(1) Congress should direct HCFA to nullify the new cost limit structure and expressly forbid their implementation during the period of the freeze on Medicare provider's reimbursement.

(2) Congress should direct HCFA to fully withdraw the proposal to eliminate the presumption of waiver of liability.

(3) Congress should enact legislation to statutorily define "intermittent care", S. 778 and H.R. 2371, as soon as possible.

These actions would go far in protecting the Medicare beneficiary's right and access to home health care. I thank the members of this Committee for their sincere interest in obtaining this goal, and look forward to joining and supporting your efforts. Thank you

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ADMINISTRATIVE GUIDES

Examine the individual case worksheets and identify those claims where the contractor determined that payment was made improperly. Review the payment records for those claims to determine whether the claim was retrospectively denied and whether overpayment recovery was initiated where necessary. Assure that the case worksheet was completed for each beneficiary reviewed by the contractor in accordance with instructions in section 2300.3E of HCFA Pub. 13-2.

Element 15—Conduct 100 percent prepayment review of HHA providers where required.

Performance levels: 10 = 100 percent of the sampled claims had been subject to prepayment medical review; 0 = Less than 100 percent of the sampled claims had been subject to review.

Weight 3: Method of RO Evaluation—Examine the HHA coverage compliance quarterly reports and identify those providers where the contractor found noncovered services in more than 5 percent of the visits. (These providers are subject to 100 percent prepayment review per HCFA instructions.) Take a sample of claims from the quarter following the quarter of review from a sample of providers which were subject to 100 percent prepayment review.

Examine the contractor's documentation to determine whether the claim had been subject to medical review by the contractor. (Clerical review is not sufficient effort to meet the requirement under this element.) Consider the absence of a medical record on the claim as evidence that a medical review was not conducted.

Element 16—Administer a cost effective MR/UR program.

Performance levels: Note—Costs must account for 95-100 percent of funds approved by HCFA for MR/UR. If 95-100 percent of funds approved for MR/UR are expended, take the following action: 10 = $15.01/1 or more, 9 = $10.01/1-$15.00/1; 8 = $6.01/1-$10.00/1; 7 = $5.00/1-$6.00/1; 6 = $3.50/1-$4.99/1; 4 = $2.50/1-$3.49/1; 2 = $2.00/1-$2.49/1; 0 = $1.99/1 or less.

Element 14—Properly perform TEFRA audits and target amount computations.

Performance levels: 10 = Outstanding, 7 = Satisfactory; 0 = Unsatisfactory.

Weight 5 (Critical): Method of RO Evaluation—The Quality Evaluation of Settlements under TEFRA (QUEST) will be used for this review. Information pertaining to this review program will be furnished from Central Office by the Bureau of Quality Control

Element 15—Properly finalize HHA cost reports.

Performance levels: 10 = Outstanding, 7 = Satisfactory; 6 = Needs improvement; 0 = Unsatisfactory.

Weight 3: Method of RO Evaluation—Use the results of the HCFA Home Health Agency Reimbursement Review Program (HHA-RRP). This evaluation applies only to the 49 designated HHA intermediaries.

Element 16—Administer a cost effective provider audit program.

Performance levels: 10 = 700 or more; 9 = 6.00-6.99; 7 = 5.00/1-5.99/1; 6 = 3.00/1-4.99/1; 4 = 1.00/1-2.99/1; 0 = less than 1.00/1.

Weight 5 (Critical):

PREPARED STATEMENT BY MORRIE LEVY, EXECUTIVE DIRECTOR, ANN HOWARD, LEGISLATIVE DIRECTOR, AMERICAN FEDERATIONS OF HOME HEALTH AGENCIES

SUMMARY

The American Federation of Home Health Agencies conducted a survey 5,000 Medicare certified home health agencies in March to obtain cases to illustrate the impact that loss of waiver of liability would have on home health providers and

Medicare beneficiaries. We received 401 cases of total or partial denial of home care services provided over the last two years.

Currently home health agencies with a denial rate of 2.5 percent or less can be paid for denied services if it is determined that the home health agency did not know or could not have known that the services were not reasonable and necessary, or constituted custodial care. The Health Care Financing Administration issued proposed regulations (Federal Register, February 12, 1985) to eliminate an effect waiver of liability protection for HHAs, skilled nursing facilities, and hospitals.

The attached cases are precedent setting for HHAs providing home health services denied in whole or part, but covered under waiver of liability. If the favorable waiver presumption is lost, presumably in the future, patients of the type illustrated here would not be able to receive the home health services their physicians order. Although these cases are intended to illustrate specifically the waiver of liability issue, they indicate that there are seriously ill Medicare beneficiaries who are not receiving the home care services they need.

In 1983, the last year for which we have figures, an estimated 1,320,000 Medicare patients received home health care. Eighty-five percent of HHAs are on waiver, with a denial rate of less than 2.5 percent; 32.4 percent of denials were reversed at reconsideration by fiscal intermediaries.

A number of cases not reversed are appealed to administrative law judges and to the Federal Courts. Between October 1, 1984, and February 28, 1985, administrative law judges decided 840 cases involving Part A Medicare denials. Denials were reversed in 57.6 percent of these cases. (We have not been able to break down this figure by type of provider.)

The 401 cases we received came from 32 states, with patients ranging in age from 26 to 98. The number includes 38 disabled beneficiaries; the others are elderly patients with a median age of 78.

A disproportionate number, 39 percent, come from just three states—Florida, Illinois, and Georgia. Ninety-nine percent have multiple diagnoses; many are extremely debilitated and have an ailing elderly spouse or live alone.

The most frequent diagnoses are cancer, cardiac and circulatory ailments, and complications of diabetes.

Attached we have provided a chart of 50 cases from all areas of the country, illustrating the range of circumstances we found: patients who recovered with home health care, and others who ended up being institutionalized or who died; post hospital and nursing home patients, and those with no prior institutionalization; denial of all services, denial for a period of weeks or months, and denial of a portion of services during the whole course of care.

Of the 50 patients on the attached chart: 79 is the median age, 12 received denial of all home health services, 12 lived alone; 35 are post hospital cases; 13 had to be (re)institutionalized; and 19 died.

SAMPLE CASES

Mid-Atlantic—An 82 year old widow living alone in a rural area, suffering from bowel obstruction, acute urinary tract infection, dehydration, gall stones, and degenerative joint disease; on multiple medications. During three week course of care with home health agency, intestinal problem stabilized and patient was given nutritional instruction. All visits were denied on the basis that services could be performed by a nonmedical person. Subsequent to discharge, patient was readmitted to hospital with another bowel obstruction.

Midwest—76 year old patient with colon cancer which had spread to the liver. He was admitted to home care after discharge from the hospital. He had a Hickman Catheter for chemotherapy that required daily flushing and weekly sterile dressing changes; also had a urinary catheter and required care for a hip incision. The patient deteriorated, was rehospitalized, and died. Four of twelve nursing visits provided to this dying patient prior to rehospitalization were denied as not reasonable and necessary.

South—A 92 year old patient with acute infected lesions and growths following removal of skin cancer on scalp, face, neck, and hands. Also suffered from angina, arteriosclerosis, hypertension, and crippling arthritis. This elderly beneficiary lived alone, had poor eyesight and hearing, was inadequately nourished, confused, and incapable of caring for self. The intermediary allowed services for the first and third months of care, but denied services in the second month, claiming that the services could have been provided by a nonmedical person. The patient's condition was most acute in the month for which all care was denied.

South—84 year old bedridden woman suffering from kidney failure, but not on dialysis; she also had congestive heart failure, high blood pressure, lung congestion, lupus, and severe hip pain. She deteriorated steadily and entered hospital for treatment of these conditions. Upon discharge, home health services were covered for five days, then all were denied on the claim that care could be provided by a nonmedical person. The patient was readmitted to the hospital and died two days later.

South—83 year old patient with terminal cancer of the liver, weight loss, a draining biopsy site, urinary tract infection, constant nausea and vomiting, coughing up blood, and mental confusion. Patient's 79 year old wife unable to care for him because of stroke and coronary condition. Patient's condition slowly deteriorated, requiring frequent medication changes, and wound care. Beginning five weeks after admission to home care services, the intermediary denied all visits, claiming that the services could have been effectively and safely provided by a nonmedical person. The patient died shortly after services were denied.

West—88 year old woman with terminal cancer, a fractured hip, skin ulcers, and congestive heart failure. Patient, who lived alone, was discharged from hospital to home care; agency worked with family members in the area to keep her home. All home health services were denied; according to the intermediary, this beneficiary did not require skilled nursing care. Consequently, patient had to be admitted to a nursing home where her condition deteriorated and she died.

West—87 year old man with chronic obstructive pulmonary disease and high blood pressure. Because of blindness, deafness, and death of his wife during the course of care, patient needed visits for safety, monitoring of treatment compliance and potassium level in blood, and chest drainage treatments. This man was stable and independent until services were denied, on the claim that skilled care was not required. Patient died one week after services were denied. Agency was told appeal would do no good. Intermediary said "Write your Senator."

MEDICARE HOME HEALTH CARE DENIALS

50 SAMPLE CASES

CASE #	AGE SEX (IF KNOWN)	DIAGNOSES PRIMARY/SECONDARY - SIGNIFICANT COMPLICATIONS	PERTINENT MEDICAL & SOCIAL FACTORS	SERVICES ORDERED BY PHYSICIAN *	SERVICES DENIED	FISCAL INTER-MEDIARY'S REASON FOR DENIAL	OUTCOME (IF KNOWN)
12	82 F	bowel obstruction acute urinary tract infection (UTI) gall stones osteoarthritis dehydration	post hospitalization lives alone in rural area on multiple medications	RN 2x week for lab work, diet teaching, treatment of UTI and severe diarrhea	all services	non medical person could perform	rehospitalized with another bowel obstruction; prognosis poor
13	79 F	cancer of breast, metastasized to spine and rib cage diabetes — hypertension urinary tract infection arteriosclerosis	post hospitalization confusion, leading to non compliance with treatment on multiple medications lives with unmarried son	RN daily HHA 3 x week; for packing and treatment of mastectomy wound and other conditions	18 of 30 RN visits for one month	non medical person could perform	wound slowly improved
16	71	terminal bronchial cancer diabetes anemia hypertension stricture of esophagus	lived with daughter who works had gastric tube; on oxygen needs assistance with daily activities; weak; difficulty walking	RN 3x week HHA 5x week; for tube feeding and dressing change to tube site	2 of 5 weekly HHA visits	medically unnecessary	rehospitalized; died four weeks later
22	83 F	acute respiratory infection congestive heart failure chronic brain syndrome fecal impactions severe diarrhea dehydrated	lives with elderly spouse very confused bed bound poor living conditions	RN 1x week HHA 3x week	all services	condition appears to be regulated within acceptable limits	hospitalized; died
63	83	small strokes colitis cataracts dehydration asthma anemia kidney disease arteriosclerosis congestive heart failure	post hospitalization lives alone depression on multiple medications	RN 4 consecutive days, tapering off to 1x every 2 weeks	all but first 18 visits for 2 month period	not reasonable and necessary	improved, discharged
64	70	pneumonia GI bleeding skin ulcers rheumatoid arthritis congestive heart failure hypertension arteriosclerosis hiatal hernia	post hospitalization anxiety on multiple medications	RN 2x week, then tapering off	all but 1 RN visit	not reasonable and necessary	died
76	68 M	3rd degree burns both legs diabetes chronic obstructive pulmonary disease edema urinary tract infection	post hospitalization obese patient, infirm wife, and immature grandchild unable to perform dressing changes	RN daily; for dressing change on burn sites	all but 1 RN visit weekly	patient had been instructed in dressing technique	complications avoided
77	74 F	breast cancer, metastasized to lungs monthly chemotherapy treatments edema	post hospitalization lives alone greatly weakened serious falls at home	RN weekly; for nutritional, respiratory and post chemotherapy instruction and monitoring	all RN visits after first four months	not skilled service	

91	76 M	colon and liver cancer hip fracture with pinning periodic chemotherapy treatments lung congestion constipation	post hospitalization confined to bed or wheelchair wife mentally and physically incapable on multiple medications Hickman catheter for chemotherapy	HHA 3x week RN 3x week for dressing changes, daily irrigation of Hickman catheter and Foley catheter, bowel management, monitor vital signs, pain control, drug response	4 of 12 RN visits	not reasonable and necessary	rehospitalized died
112	84 M	lower base of spine Parkinson's disease organic brain syndrome	lives with elderly wife who has cardiac condition bed bound totally dependent	RN every 1-2 weeks HHA 3x week	all services	non medical person could have performed	died
114	93 M	congestive heart failure arteriosclerosis diabetes edema	post hospitalization lives alone progressively weaker multiple medications	RN 1 every 2 weeks HHA 2x week	all services	non medical person could have performed	died
[illegible]	[illegible] M	cancer of larynx; laryngectomy wound infection post surgery for lesion on lung fistula of esophagus chronic lung disease arteriosclerosis	post hospitalization patient and wife extremely anxious, overwhelmed tracheostomy tube suction machine and catheter tube feeding	HHA 3x week RN daily tapering off to 1x week for wound and tube care, instruction to patient and family	4 of 11 RN visits	inappropriate utilization	
[illegible]	[illegible] M	extensive surgery; amputectomy deep open wounds each leg hip replacement severe allergic reaction to transfusion	post hospitalization on multiple medications	RN daily 2x week tapering off after that	6 of 19 RN visits for third to seventh week on service (denials reversed)	overutilization	leg wounds healed slowly
132	88 F	terminal cancer hip fracture ulcer of sacrum congestive heart failure	post hospitalization lives alone in severe pain	RN 1x week HHA 2-3x week	all services	did not require skilled nursing care	with denial of home health services, had to enter nursing home; died
133	[illegible] M	chronic obstructive pulmonary disease hypertension	blind; poor hearing recent widower	HHA 1 every 1-2 weeks RN 1x month for percussion and postural drainage, monitor potassium level and compliance	all services	did not require skilled nursing care	died within a week of denial
[illegible]	88 M	skull fracture urinary tract infection, degenerative joint disease diabetes	progressive debilitation severe hearing loss dependent for daily needs	RN 1x week for teaching, lab tests, gait training	all services	skilled care not required	died
[illegible]	82	stroke; unable to swallow skin ulcers malnutrition GI bleeding leg amputation congestive heart failure lung congestion	bedbound with restraints confused multiple medications incontinent; Foley catheter Dobhoff tube caregiver friend slow to comprehend	RN 2-3x week and as needed HHA 3x week	27 RN visits 4 months (denial of HHA visits reversed)	number of visits not reasonable and necessary	hospitalized

137	75 F	end stage chronic obstructive pulmonary disease	husband died during 3rd month of care unable to care for self hired live-in companion on oxygen	RN 1-2x week for lab work, monitor medications and congestion	all visits after 10th week	non medical person could have performed	died (2 days after last visit)
138	81 M	terminal cancer of liver urinary tract infection coughing up blood draining biopsy site weight loss unrelieved nausea and vomiting	mental confusion elderly wife suffering from stroke, heart condition multiple medications	RN 1-2x week HHA 1-3x week	all services	non medical person could have performed	hospitalized; died
[illegible]	[illegible] F	colon cancer with metastasis inflammation of stoma nausea and vomiting edema	post hospitalization lived with elderly spouse post chemotherapy bedridden incontinent	RN 2x week HHA 3x week	7 of 8 RN and 4 of 12 HHA visits	did not require skilled nursing care	patient improved
141	54 F	kidney failure; not on dialysis lupus heart failure hypertension lung congestion ulcers on heels	post hospitalization bedridden cannot be left unattended Foley catheter severe hip pain	RN 2-3x week HHA 1-2x week	14 RN and 3 HHA visits; all visits after first days post hospital	non medical person could have performed	rehospitalized; died
143	78 F	post craniotomy and partial removal of small intestine hydrocephalus with partial paralysis abdominal shunt kidney failure partial intestinal obstruction cerebral deficiency; stroke diabetes; anemia cellulitis of legs	multiple hospitalizations elderly spouse totally dependent Foley catheter, tube feedings	RN 3x week tapering off HHA 5x week tapering off	3 RN and 6 HHA visits (denial of HHA visits reversed)	not reasonable and necessary	
[illegible]	[illegible] M	terminal bone cancer with metastasis ulcer at base of spine	post hospitalization severe weakness incontinent in severe pain elderly wife unable to prepare injections for pain; grandchild unwilling continuous deterioration	RN 3x week or as needed	9 of 14 RN [illegible] for [illegible] month of service; allow 1 per week	duplication of family care	died end of third month on service
181	65	congestive heart failure arteriosclerosis infected leg ulcer	multiple hospitalizations decrepit residence poorly educated on multiple medications	RN 1x week	all visits	not reasonable and necessary	ulcer improved
182	61 M	stroke with partial paralysis ulcer on hip severe dermatitis	post hospitalization bedbound, in fetal position elderly ailing spouse	RN 1x week HHA 2x week	all visits	not reasonable and necessary	
185	80 M	acute congestive heart failure acute pulmonary edema blood clots in eye vertigo rapid heartbeat	post hospitalization patient and spouse very apprehensive on multiple medications on oxygen	RN 3x week tapering off	7 of 9 visits	not reasonable and necessary	
187	75 F	acute psychosis: paranoid, withdrawn, fearful arteriosclerosis unstable hypertension rapid heartbeat organic brain syndrome	post hospitalization confused her multiple medications; possible overdoses; medication changes abandoned by impatient relative	RN 2x week HHA 3x week	17 RN and 35 HHA visits for 3rd - 5th months on service	not reasonable and necessary	steady progress; markedly improved upon discharge
[illegible]	79 M	prostate and bone cancer	post hospitalization lived alone weight loss; poor appetite weakness increasing pain suffered blackout with head injury	RN 2x week, reducing to 1x week HHA 3x week PT 2-3x week for 1 month MSW 1-2x month	1 of 3 HHA for 3rd month all services 4th - 5th months	supportive care; not reasonable and necessary	died in 6th month of care

224	82 F	diabetes congestive heart failure (CHF) leg amputation for gangrene edema	post hospitalization and nursing facility blind changes in medication	RN 1x month for monitor diabetes, medication changes, signs of CHF, skin problems and edema; compliance with diet	all visits	not reasonable and necessary	
237	73 M	lung cancer chronic obstructive pulmonary disease arteriosclerosis osteoarthritis drug allergy skin ulcer vomiting blood	severe weakness and shortness of breath on oxygen confused, hostile, hallucinations	RN 3x week, reduced to 1x week, increase to 2x week following hospitalization	all visits after third week	not require skilled nursing care	died
		malnutrition bleeding ulcer of esophagus anemia urinary tract infection leg abrasion	post hospitalization extremely weak weight declined to 75 pounds on multiple medications	RN 1x week and as needed HHA 3x week	3 RN, 9 HHA visits for 2nd/last month	inappropriate utilization	
244	80 M	post surgery for dislocation of shoulder stroke cerebral atrophy diabetes pulmonary fibrosis osteoporosis	post hospitalization lives alone has been extremely independent	RN 2-3x week HHA 4-6x week for 2 weeks, then decrease PT 2-3x week	16 of 26 HHA visits	not reasonable and necessary (f.i. stated patient should have been in nursing home)	rehabilitated
247	78 F	perforated cancer of colon, colostomy diabetes	post hospitalization weakness poor nutrition rapid deterioration	RN 3-4x week HHA 2-3x week	22 RN and 20 HHA visits	non medical person could have performed	rehospitalized died
271	95	post surgery for fractured hip arteriosclerosis kidney infection edema	out of nursing home deaf alone during day multiple medications	RN 2x week, reduced to 1x week HHA 3x week x60 days	4 RN and 11 HHA visits	no acute changes necessitating home health care	progressed to walking with walker
282	76 F	congestive heart failure diabetes arteriosclerosis edema	multiple hospitalizations multiple medications; confused her medications sporadic acute symptoms	RN 2-3x week	all RN for 12th and 13th months	not reasonable and necessary	rehospitalized; died in month following denied home health services
286	77 M	post abdominal surgery cancer of colon continuous GI bleeding decreased heart size	post hospitalization frequent change of multiple medications extremely weak	RN 3x week MSW 2 visits	5 RN visits	not reasonable and necessary	
287	81	arteriosclerosis organic brain syndrome glaucoma severe fungal infections of feet	blind lives alone bedridden extremely weak	RN, HHA, PT, OT 2-3x week (PT for ambulation)	8 PT visits	not reasonable and necessary	became stronger
294	80	heart attack surgery for nasal cancer diabetes hypertension	post hospitalization confused constant chest pain incontinent	RN 1x week and as needed	10 RN visits in 2 months after admission	no acute changes necessitating home health care	
296	64	cancer of kidney urinary tract infection anemia hypertension small strokes cardiac irregularity; elevated potassium level post stomach and abdominal surgery GI bleeding anorexia lung congestion	on multiple medications incontinent extreme weakness acute symptoms	RN 3x week	51 RN visits over 4 months	chronic condition; no acute changes	
298	75	cancer of colon; colostomy cancer of liver and lungs infection of incision	post hospitalization	RN daily x2 weeks tapering down to 2x a week	9 of 18 visits (denials reversed)	not medically necessary	

115	72 M	amyotrophic lateral sclerosis chronic obstructive pulmonary disease dehydration inability to swallow	several hospitalizations oxygen dependent rapid deterioration	RN 1x week	all RN visits in 2nd month (denials reversed)	non medical person could have performed	hospitalized; died
[illegible]	[illegible] M	arteriosclerosis history of urinary tract infection incontinent; had Foley catheter, skin open and draining heart attack congestive heart failure	post hospitalization and nursing home on multiple medications	RN 1 every 1-2 weeks HHA 1x week	2 RN and 11 HHA visits in 3rd month (denials reversed)	not reasonable and necessary	
138	84 F	draining sacral skin ulcer metastatic lung cancer	post hospitalization on multiple medications	RN 1x week and as needed HHA 3x week	all RN for 3rd-6th months	not require skilled care	
146	74 M	cancer of prostate removal of testicles urinary tract infection periodic radiation therapy	post hospitalization severe depression weak in pain steady deterioration no appetite	RN 1x week decreasing to 2 HHA 4x week decreasing to 3	15 RN visits	non medical person could have performed	rehospitalized
162	79 M	cancer of lung, liver, pelvis chemotherapy treatments degenerative joint disease	post hospitalization primarily bedridden elderly anxious spouse	RN 2x week PT 2x week HHA 2x week	all visits	not require skilled care	died
164	[illegible] M	quadriplegia hypertension degenerative osteoarthritis	lives alone, no family bedridden alcoholic	PT 3x week	2 PT visits per week	not reasonable and necessary	learned to transfer from bed
168	80 M	acute abscess of thigh post surgery on thigh cardiac irregularity	post hospitalization disabled elderly spouse on multiple medications pain and shortness of breath	RN daily for wound packing and irrigation, monitoring vital signs, medication and nutrition guidance HHA 3x week	42 RN visits in 4th and 5th months after rehospitalization	not reasonable and necessary	condition very unstable
171	81 F	amyotrophic lateral sclerosis tracheostomy post partial removal small intestine gastrostomy with tube feedings	post five month hospitalization respirator dependent Foley catheter spouse unable to cope with care suction machine on multiple medications condition terminal	RN daily HHA 7x week	30 RN and HHA visits in first month	not reasonable and necessary	
188	71 F	cancer of uterus and lung post lung surgery pernicious anemia anorexia	post hospitalization lives alone generalized weakness insomnia, pain, anxiety	RN 3x week tapering off	all visits after first 10 days	non medical person could have performed (all denials reversed)	
189	92	infected skin lesions of scalp, face, neck, hands; dermatitis, keratosis post surgery removal of skin cancers hypertension arteriosclerosis; angina arthritis small strokes	lives alone poor vision and hearing diminished mental capacity unable to care for self inadequate nutrition	RN 2x week tapering off HHA 3x week increasing to daily to treat infections	all visits after 3rd week (denials for 3rd month reversed)	non medical person could have performed	infection cleared; discharged

* RN - skilled nursing OT - occupational therapy
HHA - home health aide MSW - medical social work
PT - physical therapy

The CHAIRMAN. Thank you very much.

Ms. Struve, please?

STATEMENT OF KAREN STRUVE

Ms. STRUVE. Mr. Chairman, and members of the committee, my name is Karen Struve, and I am the president of Walker Methodist Residence and Health Services in Minneapolis, MN. Today, I represent the American Health Care Association and the American Association of Homes for the Aging, but more important, I represent thousands of Americans throughout the country that are being denied skilled nursing home care coverage; really, the broken Medicare promise.

There are two major problem areas which we want to discuss, coverage issues and the proposed freeze on skilled nursing care benefits.

Qualifying for Medicare nursing facility care in this country has always been a problem since the 1970's, but today it has really reached crisis proportions. My own facility in Minnesota has gone from 190 certified skilled Medicare beds to 10, the reason being, we could never find enough residents that would meet the stringent requirements of our intermediary.

The promises being broken, the 24-hour skilled care coverage in the nursing home that the law specifies is not being provided.

Even when there is a possibility of rehabilitation potential, nursing homes throughout the Nation, report that coverage is not granted because the intermediary insists it should be delivered in the home, regardless of the physical condition of the person or the family situation, not a viable situation for a 92-year-old person that is deaf and has a broken hip.

In our survey of 1,000 skilled nursing facilities certified for Medicare, only 3.7 percent of more than 22,000 beds are occupied by Medicare patients. Likewise, 35 percent of them did not have one Medicare person in the bed.

With this bleak picture as a backdrop, the administration has now taken greater steps to wipe out any remaining vestige of the Medicare Skilled Nursing Program.

On March 14 of this year, the administration proposed eliminating the waiver of liability coverage. Not content to rely solely on the elimination of this benefit, HCFA has also recently changed the way it calculates the waiver days.

The new methodology, rather than using the total number of cases in the denominator, which are supposed to be representative, uses a sample of the denial cases in the gray area.

This is not statistically even sound. Our survey has shown that 43 percent of the respondents reporting that their intermediary coverage has grown stricter within the last year, and 17 percent of our members have said that they would drop out of the program if the waiver of liability is denied.

It is really no mystery why HCFA continues to change the procedure. Every beneficiaries denied service equals dollars saved. We estimate nationwide one-half of the providers who currently have waiver status will lose them.

In addition to the problems of waiver of liability and sampling methods, the whole contractual relationship between the intermediary and HCFA should really be explored.

Under element 16 of the Health Insurance Manual, an intermediary must save $5 in benefits, Medicare skilled nursing benefits, for every dollar of its administrative costs, or it is in jeopardy of having its contract terminated.

This is truly an incentive to reduce Medicare benefits to the older American. The administration has also proposed freezing section 223 of the cost limits for all providers. This freeze would only serve to increase the access problems that already exist in skilled nursing facilities.

It should be noted that nursing homes have never contributed to the Medicare cost containment problem, and very little savings would result from freezing the SNF portion of the budget, rather, the problem of access would increase.

A few of our recommendations: HHS should not proceed with regulations to limit the waiver of liability. The new sampling procedure, which is not statistically based, should be abandoned.

Intermediary incentives to deny coverage for Medicare recipients should stop. And section 223 limits for skilled nursing facilities should not be frozen.

Mr. Chairman, the efforts of this administration to engage in the slashing of benefits to the elderly are irresponsible and ill-conceived. We must prevent this.

Thank you.

[The prepared statement of Ms. Struve follows:]

PREPARED STATEMENT OF KAREN STRUVE, PRESIDENT, WALKER METHODIST RESIDENCE AND HEALTH CARE SERVICES, INC., MINNEAPOLIS, MN ON BEHALF OF AMERICAN ASSOCIATION OF HOMES FOR THE AGING, AND AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and Members of the Committee, I am Karen Struve, President of the Walker Methodist Residence in Minneapolis, Minnesota. I am here today on behalf of the American Health Care Association (AHCA) and the American Association of Homes for the Aging (AAHA). More important, however, I am here on behalf of the thousands of elderly and needy Medicare beneficiaries who are daily being denied care in skilled nursing homes because of cost reductions directed from Washington. Most of these people are too frail and sick to come here and tell you about their problems. If they could, they would tell you about how impossible it is to receive coverage from intermediaries who are deciding arbitrarily that they are ineligible for skilled coverage in contravention of the Medicare law and about the difficulties they are having in finding nursing homes which will accept them because the homes have lost their Medicare waiver of liability.

The elderly have truly become victims of a system in which they are discharged earlier, and sometimes prematurely, as a result of the new hospital DRG payment system, yet cannot obtain the post-hospital benefits to which they are entitled and which they desparately need now more than ever. The concerted effort by the Health Care Financing Administration (HCFA) to deny Medicare benefits to the elderly is similar to the Administration's ill-founded attempts to purge the disability rolls several years ago in the name of cost savings.

Our two associations recognized that the problems with Medicare rules were driving nursing homes out of active participation in the Medicare program and leading to access problems for the beneficiaries. Both associations have joined with a coalition of consumers and providers on the waiver of liability issue. The drastic steps taken by the Administration to virtually eliminate the skilled nursing facility (SNF) benefit had lead to an effective bonding of interests between consumers and providers. We commend the Committee for its attention to this vital issue and fervently hope this hearing will serve as the catalyst for initiating action to resolve these issues.

There a 2 major Medicare problem areas which we would like to address today: 1. Coverage Issues, 2. Proposed Freeze on SNF Reimbursement.

COVERAGE ISSUES

The low numbers of individuals qualifying for Medicare skilled nursing facility care has been a problem since the early 1970's, but today it has reached crisis proportions. While Congress intended the benefit as an extension of a hospital stay for patients needing skilled nursing or rehabilitative care, the current Administration has so narrowly construed eligibility, that we frequently have terminally ill patients being denied coverage. My own facility in Minnesota has gone from 190 certified Medicare beds to only 10 because there were never sufficient patients who could meet the overly restrictive eligibility criteria for Medicare set out by the intermediary. Patients who require 24 hour skilled care or skilled nursing supervision are not permitted coverage, even though the law specifies they should be. Our intermediary only grants coverage to patients who have rehabilitative potential, obviously not a feasible goal when you are deaing with an 89-year-old patient admitted for gastrointestinal hemorrhage, multiple peptic ulcers, arterioschlerotic heart disease and who is legally blind and deaf.

On the other hand, when there *is* a possibility of rehabilitation potential, nursing homes in Pennsylvania and throughout the nation report that coverage for rehabilitative care such as physical therapy, is *not* granted because the intermediary insists it should be delivered in the home, regardless of the patient's other medical needs or family situation. As a case in point, the intermediary in Illinois terminated coverage after less than a week on an 84-year-old patient with a broken hip *and* a broken wrist. The patient's arm was in a cast, she lived alone with only and elderly sister nearby. She still required physical therapy, yet she could not function in her home with a walker because of her wrist.

There is no question that intermediary coverage decisions under the SNF Medicare benefit are grossly inconsistent, imprecise, and biased. The arbitrary adminstration of the benefit is revealed by the 80 percent rate of reversal in successful reconsiderations brought by the Connecticut Legal Assistance to Medicare Patient Project, and has been well documented in a study published in the New England Journal of Medicine, which showed how different intermediaries interpreted Medicare SNF coverage inconsistently for 9 hypothetical cases. The authors concluded:

"Medicare coverage for skilled nursing care is not a clear cut, predictable benefit from either the physician's or the beneficiary's point of view. Instead, it is highly unpredictable and dependent on criteria that are often implicit, unwritten, and not available for perusal or comment. Differences in criteria and the application of rules of thumb must inevitably lead to disagreement not only on coverage, but on the reasoning behind reward or denial."

In a survey just completed by AAHA and AHCA, of 1,000 skilled nursing homes certified to serve Medicare patients, only 3.7 percent of the more than 22,000 beds were occupied by Medicare patients. Thirty-five percent of the homes had no Medicare patients at all.

National data confirm the serious access problem for older Americans. In 1980, one-half of the non-metropolitan counties and 17 percent of the metropolitan counties lacked any certified skilled facilities at all. Thirty percent of SNF patient days are concentrated in only two states, New York and California and 50 percent of the patient days are delivered in only six states. Total SNF Medicare covered days declined by over one half between 1969 and 1977. The impact on the beneficiary is equally alarming: a 21 percent decrease in the covered days per thousand beneficiareies occurred between 1976 and 1982. This is tantamount to a 21 percent cut in benefits at a time when eligible Medicare beneficiaries increased 20.3 percent.

The current waiver law is critical to the Medicare SNFs because it provides some protection against the kinds of retroactive denials of coverage that motivated over one half of the nation's nursing homes participating in Medicare to leave the program. The waiver of liability guidelines were passed by Congress in 1972 in direct response to providers leaving the program.

With this bleak picture as a backdrop, the Administration has not taken steps to wipe out any remaining vestiges of the Medicare SNF program. On March 14, 1985, it proposed eliminating the waiver of liability, a provision which has afforded nursing homes and other providers a cushion for coverage denials made in eligibility determinations. Under the statutory provision, the waiver provides relief to a beneficiary or provider who acted in "good faith" in accepting and providing services, later found by the intermediary to be not reasonable or necessary. Making these determinations is often impossible because the grey areas are larger than the black and white. For providers to be held liable for their "good faith" effort is simply ludicrous. Having the waiver has enabled many providers to remain in a program that has few, if any, incentives to be in it in the first place.

Not content to rely solely on eliminating the waiver to achieve benefit cuts, HCFA has also recently changed the way it calculates waivered days. Previously, a skilled nursing facility's denial rate was calculated by dividing the number of Medicare days provided into the number of days denied by the intermediary. If this figure was below 5 percent, then the nursing home was able to maintain its waiver and the denied days were paid for by Medicare. The new methodology, rather than using the total number of Medicare days in the denominator, uses a sample of cases which are supposedly representative of the total, to project a sample denial rate. Too often these samples are not at all representative or random, for they focus on the grey area cases. Lewin and Associates found the problems with the projection methodology "so severe that they completely invalidate the methodology, making it unusuable as a basis for denying presumptive waivers of liability."

The effect of this supposedly minor administrative change provides an alarming preview of what would happen if the waiver were eliminated altogether as HCFA has proposed. Within the last 6 months, scores of facilities have lost their waivers for the very first time as a result of these changes. One large group of facilities which lost their waivers reported experiencing a decrease in Medicare utilization by up to 50 percent at individual facilities and an average 28 percent decrease within the group.

These figures are also reflected in the AHCA-AAHA survey wherein 43 percent of the respondents reported that their intermediary coverage decisions had grown stricter within the last year. We asked these providers what actions they would take if the waiver were eliminated altogether and 16.5 percent said they would drop out of the program completely. Respondents reported they would reduce Medicare admissions by an average 26.6 percent and decreases days submitted for coverage by 28.1 percent.

It is no mystery why HCFA has changed its sampling procedures: every beneficiary denied services equals dollars saved by the program. One intermediary in the midwest has told providers that the intermediary is having to pay for its past errors by showing a month by month reduction in Medicare patient days. As a consequence, the provider responding to our questionnaire had experienced a 75 percent reduction in Medicare-covered patient days since May 1984.

An analysis of HCFA's new sampling process by Lewin and Associates, an independent consultant, found "errors and omissions" representing violations of "fundamental and elementary principles of statistics". It would seem that HCFA will stop at nothing, including rewriting the laws of statistical sampling, to achieve its cost savings goals. We estimate that nationwide, one-half the providers who currently have waiver status are likely to lose them unjustly as a result of these sampling changes.

Mr. Chairman, this country has come to a sad state of affairs if the Department of Health and Human Services has to cheat the elderly out of their benefits in order to save money. AAHA and AHCA call on HHS to halt this ill-conceived sampling process.

In addition to problems with the waiver of liability and sampling methods, the whole contractual relationship between the Health Care Financing Administration and intermediaries is worth discussing briefly, for it brings serious questions to mind.

For example, just like traffic cops who are expected to write a certain quota of tickets, a priority consideration in the evaluation of intermediaries by HCFA is the dollars saved by reducing utilization versus dollars expended in achieving those reductions. Element 16, of Sub-Section 2901.1 (Contractors Performance Evaluation Program) of the Health Insurance Manual (13-2) set this ratio as a minimum of 5-1, that is, an intermediary must save $5 in utilization reduction for every dollar of its administrative cost. If the intermediary falls below this ratio, it is in jeopardy of having its contract terminated by HCFA. Ironically, it is to the benefit of the intermediary to deny coverage in order to meet its quota, because if the case is later overturned, it is not charged back against the intermediary's quota.

Another potential conflict of interest exists for intermediaries which also offer Medigap insurance. Essentially this is private insurance purchase by the elderly which supplements Medicare, but the policyholder does not qualify for it until he or she becomes eligible for Medicare. Thus the imtermediary is placed in the potentially conflicting positions of determining eligibility for Medicare benefits which could also result in additional expenses to the intermediary through payout on the Medigap policy. This circumstance provides a double incentive for intermediaries to deny coverage: it helps them meet their quota for cost effectiveness *and* it saves them from paying out on the private insurance policy themselves.

The beneficiary is truly caught in a no-win situation by the Department's efforts to reduce services and utilization. The most unfortunate part is that the need for these services has reached a critical point thanks to the earlier discharges precipitated by the hospital DRG payment system. We must not abandon the elderly to their own devices. The Medicare SNF coverage issue must be met head-on and a solution found before it is too late.

One solution that we propose is the reinstitution of front end review in which the intermediary approves coverage for a patient at the beginning of his stay for a specific number of days. Recertification would take place for additional days if appropriate. This approach was used with some success about ten years ago and since it affords both the provider and the beneficiary some measure of protection against retroactive denials, we believe it is worth considering.

FREEZING THE SNF COST LIMITS

The Administration has proposed freezing Medicare Section 223 cost limits for all providers, including skilled nursing facilities. This freeze would serve only to exacerbate the access problems that already exist in SNF's. Despite the fact that Congress, in enacting the Section 223 cost limits, stated that the limits would apply to a relatively "small number of institutions" and only in "cases with extraordinary expenses," more than two-thirds of the facilities in states with high rates of participation were being constrained by the cost limits last year. The percentage is, no doubt, higher this year due to the greater intensity of services needed by patients discharged under the hospital DRG system. Fully two-thirds of our survey respondents reported an increase in the acuity level of Medicare patients, with over 56 percent reporting an increase in the demand for SNF Medicare services. Those facilities are losing money every time they admit a Medicare patient and can hardly be blamed if they drop out of the program.

The HCFA SNF prospective payment report also showed that homes with greater involvemenet in the SNF Medicare program had significantly higher costs than average. Our survey fully supported these conclusions, for 87.5 percent of those providers with 10 or more Medicare patients reported that they were already at or over the Section 223 limits. As the HCFA report recently stated, "For these facilities and those approaching the cost limits, the current system rewards providers who serve light care patients because the higher costs for treating heavy care patients are not recognized in the flat rate per day retrospective reimbursement limit system in effect."

A variety of sources, including our own survey, documented the greater need for more intensive skilled care that has arisen because of the DRG prospective payment system. Three recent studies have shown that patients were being discharged sicker and quicker from hospitals; a study by the National Center for Health Services Research, a survey of states ombudsmen, and a preliminary GAO report. In addition, a June 25, 1985 article in the Wall Street Journal described some of the problems these patients were having in obtaining the post-hospital care they needed. Senator John Heinz referred to this state of limbo for the Medicare patients as the "no care zone." We ask that it be made part of the hearing record.

It should be noted that nursing home costs have never contributed to the Medicare cost containment problem and very little savings would result from freezing the SNF portion of the budget. Unlike hospitals, increases in Medicare expenditures and per diem costs for SNFs have been consistently below the rate of inflation. Additionally, expenditures on nursing homes now constitute less than *one-percent* of total Medicare spending—down from 6.2 percent in 1967—significantly lower than payments to physicians or home health agencies under the program, and even lower than the error rate in payments to hospitals. Projected savings of $5 million from a freeze of the SNF Medicare budget not only ignores the increases in *total* Medicare spending that would result, but also fails to consider the tremendous difficulties that beneficiaries would face in not receiving the appropriate post-hospital services they now so urgently need.

While coverage is being restricted and sicker patients are in desperate need of care, already inadequate reimbursement rates are being ratcheted down to a point where quality rehabilitative care cannot be provided without incurring financial loss. For the vast majority of providers across the country, these barriers to participation are prohibitive, and beneficiaries systematically are denied the care they have been promised.

RECOMMENDATIONS

Certainly the opportunity to air these problems in a public forum is a first step towards their resolution, but only a first step.

Both AAHA and AHCA have been fortunate in working with a coalition of 17 concerned provider and consumer groups, such as the American Association of Retired Persons and the National Council of Senior Citizens, on the waiver of liability issue. The makeup of this coalition underscores the fact that this is a beneficiary issue as much as a provider issue. The group has met with HCFA requesting a postponement of the final regulations until an assessment of impact can be made. In addition, your Committee, Mr. Chairman, and the Senate Aging Committee have sent a letter to HHS Secretary Heckler asking the Department to assess the impact of the provision upon beneficiaries before taking any further action.

Here are the goals that AHCA and AAHA seek:

HHS should not proceed with final regulations to eliminate the waiver of liability.

The new "sampling" procedure should be abandoned. Any methodology employed should meet general principles of statistical sampling, and be fair in their application.

Intermediary incentives for coverage denials, quotas, etc., should be eliminated.

The General Accounting Office should undertake a short term study on Medicare SNF coverage and eligibility problems, including variations among intermediaries, HCFA/Intermediary contractual relationships, denial rates, utilization changes, intermediary/insurer conflicts of interest, hospital readmission rates, etc., with recommendations for improvement.

A blue ribbon panel should be established to report and make recommendations to Congress within one year on coverage under the Medicare SNF benefit.

Periodic official publication of the facts of coverage rationale for a representative sample of cases in the "grey" areas, including observation, assessment, and overall management of patients with multiple problems. This information should be made available to the general public.

Statistics on the administration of the skilled care benefits by individual Medicare intermediaries should be compiled to help facilitate intermediary performance review by HCFA.

There whould a standardized program of training for intermediary personnel performing reviews to ensure that reviewers and their supervisors completely understand the criteria for coverage and they way these criterias are applied.

Providers should be permitted to act on behalf of and as advocates for patients denied Medicare coverage.

The feasibility of reinstituting front end review by intermediaries should be explored by HCFA and reported to Congress.

Section 223 limits for skilled nursing facilities should not be frozen; HCFA should review the process through which nursing homes can obtain exceptions to the limits.

Mr. Chairman and members of the Committee, the efforts of this Administration to engage in a slashing of benefits to the elderly are irresponsible and ill-considered. The Department of Health and Human Services' own projections concerning hospital backup days portend a multi-billion dollar expenditure in the next five years: nearly 1½ million Medicare backup days and 8 million Medicaid days of patients in hospitals awaiting nursing home placement. This translates into a minimum of $3.8 billion in additional program expenditures if the present policies are allowed to continue. We must prevent the Administration from breaking its promise to provide appropriate care for older Americans by denying access to those services the law says they are entitled to. We need your help to achieve this.

DATA PREPARED FOR HOUSE SELECT COMMITTEE ON AGING ON THE IMPACT OF COST CONTAINMENT ON ACCESS TO SKILLED NURSING FACILITY SERVICES, JULY 9, 1985, AMERICAN ASSOCIATION OF HOMES FOR THE AGING, AMERICAN HEALTH CARE ASSOCIATION

BACKGROUND

The hospital DRG prospective payment system has led to elderly Medicare patients being discharged earlier and with more acute skilled nursing service needs. This rapidly increasing demand is putting a strain on the capacity of skilled nursing facilities (SNFs) to accommodate and care for these sicker patients. Throughout the country, elderly Americans are having difficulty gaining admissions to a nursing home after a hospital stay and, in those instances when they are admitted, they often find they are ineligible for Medicare benefits. These problems are the result of recent cost-cutting efforts undertaken by the Reagan Administration.

Nursing home providers are reluctant to participate in the Medicare program because the system is characterized by inadequate reimbursement rates, restrictive and inconsistent coverage decisions, overly burdensome cost reports, and unreasonable appeals mechanisms. A nursing home administrator from Pennsylvania commented: "Skilled nursing facilities are seeing more acutely ill patients and are not receiving adequate reimbursement for their care." Another administrator from California lamented: "We decertified from Medicare 6 years ago because we seemingly couldn't get anyone covered anymore. The paperwork was increasing and coverage was less and less." The disincentives to SNF Medicare participation have led to severe access problems:

In 1980, one-half of the non-metropolitan counties and 17 percent of metropolitan counties had no certified skilled facilities; 30 percent of Medicare SNF patient days are concentrated in only two states, New York and California, and 50 percent of the patient days are in only six states; in 1982, 30 states had fewer than five SNFs with at least 16 Medicare patients while 12 states did not have any such facilities; total SNF Medicare covered days declined by over one-half between 1969 and 1977, while covered days per 1000 elderly declined by over 2 percent between 1976 and 1982.

STUDY FINDINGS

In order to find out more about the problems with the SNF Medicare program, the American Health Care Association (AHCA) and American Association of Homes for the Aging (AAHA) conducted a survey of over 1000 Medicare certified nursing homes. 172 facilities responded, totalling 22,359 beds, of which 13,476 were Medicare certified. (In 1980, 3,492 nursing homes participated in the Medicare program and had a total of 276,986 Medicare certified beds, serving approximately 245,300 beneficiaries that year.) Our survey revealed: 35 percent of the nursing homes had no Medicare patients at all; Only 3.7 percent of the more than 22,000 beds in the survey were occupied by Medicare patients; 56.4 percent reported an increase in the demand for SNF services as a result of hospital DRGs (75 percent of the facilities with ten or more Medicare patients reported such an increase); Two-thirds reported an increase in the intensity of Medicare SNF services needed as a result of hospital DRGs (85 percent of facilities with ten or more Medicare patients reported such an increase).

WAIVER OF LIABILITY

The problems with SNF Medicare coverage have grown worse recently because of new sampling procedures used and incentives for intermediaries to deny service coverage. Homes have traditionally had some protection against inconsistent, restrictive coverage decisions and retroactive denials through the waiver of liability, which was designed to insulate beneficiaries and providers from unfair liability and, thereby, ensure reasonable availability of Medicare services. Currently, homes have an incentive to submit claims for coverage which they believe will be covered because, if less than five percent of the claims submitted are denied, the home will not be held financially liable for these claims. The Administration has proposed that these provisions be eliminated. As John Rother, Associate Director of Legislation, Research and Policy for the American Association of Retired Persons has stated, "The rule change will force providers to accept only those patients for whom Medicare coverage is absolutely certain." Our survey found: 43 percent reported that their intermediaries' coverage decisions had become more restrictive within the last year; 16.5 percent reported that they would drop out of the Medicare program if the waiver of liability is eliminated as proposed; If the waiver were eliminated, respondents would reduce Medicare admissions by 26.2 percent, which would, in large part, account for a 28.1 percent reduction in the number of days all homes would submit for coverage.

SNF MEDICARE FREEZE

The Administration has also proposed in its budget package to freeze the Medicare payment limits for all providers at the 1985 levels. This provision is included in both budget resolutions passed by the Senate and House, respectively. HCFA reported that last year 35 percent of all SNFs were at or over the limits, while closer to two-thirds were at or over the limits in the six states with relatively more participants. Our survey found: 13 percent reported they would drop out of the Medicare program if the freeze were enacted; If the freeze were enacted, respondents would reduce Medicare admissions by 21.8 percent, which would, in large part, account for a 21.5 percent reduction in the number of days all homes would submit for coverage; 87.5 percent of the respondents with ten or more Medicare patients were at or over the cost limits.

The survey also asked what the provider reaction would be if both the waiver of liability were eliminated and the freeze was enacted. Our survey found that if this were to occur: 20.5 percent reported they would drop out of the Medicare program; Respondents would reduce their Medicare admissions by 36.5 percent.

CASE STUDIES

By severely restricting SNF Medicare coverage and using administrative devices to curtail homes' waiver of liability, current HCFA policy has forced providers to be extremely conservative in the types of claims they will submit for coverage. The following are four actual cases in which the home did not submit the claim for fear of being held financially liable upon the intermediaries' determination of non-coverage. In each instance, the fear was well-founded, as the claims were found not covered upon reconsideration by the intermediary. Because the patients below were fortunate enough to be represented by legal counsel, all the decisions to deny were subsequently reversed by an Administrative Law Judge (ALJ). Currently, less than 1% of all SNF Medicare claims in the U.S. are submitted for reconsideration, a fewer receive ALJ review.

Patient had severe peripheral vascular disease, gangrene of the left great toe requiring below the knee amputation of her left lower extremity, early necrosis of right toes, diabetes, severe hypertension, cholelithiasis, urinary infection. Aseptic techniques and prescription medications applied to worsening, gangreneous right foot. Amputation stump site care rendered. Observation and management on a daily basis. Despite treatment, Claimant discharged to hospital for amputation of right foot. Coverage denied by intermediary upon reconsideration. Reversed, with full coverage granted by ALJ (61 days).

Patient had peripheral vascular disease, burns of the feet requiring grafting on both feet, cellulitis of the feet, diabetes mellitus, peripheral neuropathy, atrophy of the legs, mylochronic organic brain syndrome, probable cerebral thrombosis, atonic bladder, urinary tract infection, injury of feet and new skin grafts. Skilled rehabilitation services, ongoing professional assessment of rehabilitation needs and potential rendered along with complex physical therapy regimen, Coverage denied by intermediary upon reconsideration. Reversed, with full coverage granted by ALJ (100 days).

Patient had arteriosclerotic heart disease, acute bronchitis, diabetes mellitus, bilateral glaucoma, status post bilateral below knee amputations due to chronic occlusive peripheral vascular disease. Received daily insulin injections, oxygen for shortness of breath, intake and output records, medication for depression. Observation and management of frequently changing medical condition. Nausea and vomiting requiring observation and management. Daily skilled nursing care rendered. Coverage denied by intermediary upon reconsideration. Reversed, with full coverage granted by ALJ (100 days).

Patient admitted after hospital surgery on fractured left hip, had arteriosclerotic cardial disease, trouble urinating and required catherization. Was blind with very poor hearing, and prone to confusion. Treatment program included gate training, a bland diet, bladder training, complex skilled nursing supervision 7 days a week, and skilled physical therapy 5 days a week. Patient's medical record noted that condition was unstable so that a registered nurse had to evaluate the need for medication and treatment on a daily basis, and that there was a "high probability that complications would arise in caring for the patient without skilled nursing supervision of the treatment program on a daily basis." The Medicare intermediary denied SNF coverage and was affirmed upon reconsideration. An ALJ hearing concluded that the patient did not require skilled nursing care. The ALJ's decision became the final decision of the Secretary when the Appeals Council denied review. The U.S. District Court for the Western District of New York reversed the Secretary's decision to deny coverage and remanded the case for computation of benefits.

For futhrer information contact: Howard Bedlin (AAHA) 296-5960, Donna Barnako (AHCA) 833-2050.

MEDICARE PAYMENT PLAN IS BLAMED FOR HASTY RELEASE OF AGED PATIENTS

(BY JENNIFER BINGHAM HULL)

In Michigan, the family of an ailing, 87-year-old woman is told she must be discharged from the hospital because her Medicare payments have run out. In Oklahoma and elderly man is released from a hospital even though his physician believes he needs more care. And in Maine a 73-year-old man is sent home despite pleas from his family that he stay in the hospital.

Each case reflects a growing criticism of Medicare's new method for reimbursing hospitals: the use of diagnostic-related groups, or DRGs. The system, begun in late 1983, sets a fee for 468 DRGs or health problems, thus encouraging hospitals to treat patients quickly. If the patient's treatment costs less than the rate set for his particular ailment, the hospital pockets the savings; if the patient's treatment costs more than the set rate, the hospital picks up the difference.

In the fiscal year ended last Sept. 30, the average hospital stay for a Medicare patient dropped to 7.5 days from 9.5 days in fiscal 1983. Supporters of DRG-based payments say shorter stays cut costs and help patients avoid hospital risks like infections. Quality of care, they add, hasn't suffered under the new system.

But some government officials and doctors say the system is prompting hospitals to discharge patients prematurely or to tell them, erroneously, that they must leave the hospital because their federal payments have run out. Additionally, critics say, quick discharges leave the elderly with another problem: finding health care outside the hospital. Nursing homes are full, and home-health services are often inadequate.

NO-CARE ZONE

Patients "are being sent to a no-care zone," says Sen. John Heinz (R., Pa.), chairman of the Senate Special Committee on Aging.

Finding fault is difficult. Doctors say hospital administrators are pressing them to release patients early. Hospital administrators say only doctors can decide when to discharge patients. And both groups say the federal bureaucracy has created a system that is, at times, unnecessarily rigid.

Meanwhile, say critics of the payment program, patients are mistreated and endangered, and their families are confused. Last July, for example, Gladys Roteman, 87 years old, was admitted to Lapeer County General Hospital in Michigan. Mrs. Roteman was diagnosed as having congestive heart failure, which calls for about seven days of Medicare payments. But complications kept the women in the hospital for almost a month, and the hospital had to absorb the extra cost.

At the end of that month, according to Mrs. Roteman's family, a hospital social worker, Jackie Zdenek, told them that Mrs. Roteman would have to be discharged because the payments for her ailment had run out.

After making 65 calls to local nursing homes, the hospital finally transferred Mrs. Roteman to the only facility that would accept her—200 miles away. Relatives found it difficult to reach the nursing home and didn't even learn that she had suffered a stroke soon after arriving until several days after it had happened.

"None of us were by her side when she died" in the nursing home in November, says Dawn Lietke, Mrs. Roteman's granddaughter. "I think the whole system is pretty crummy."

A hospital spokesman says that patients aren't discharged because their Medicare payments expire and adds that Ms. Zdenek is confused about how the system works. But Ms. Zdenek says: "That is the normal way we do it."

Mrs. Roteman's physician, Jeffrey Harris, says that although his patient had numerous problems, there was nothing more the hospital could do for her. While acknowledging that the nursing home was impractical, he says that the scarcity of nursing-home space and the pressure in hospitals to release patients mean the solution "right now . . . is any place they can get them in, within reason. It's a big problem."

The establishment in each state of peer review organizations, or PROs, to police the Medicare program, further complicates the discharge issue. The federally financed groups generally set standards for admitting and releasing patients. They can also punish doctors and hospitals who fail to comply with those standards by removing them from the Medicare program. Some doctors are running scared.

In January, Floyd Lane, 82, was admitted to Henryetta Medical Center in Henryetta, Okla., with a urinary-tract infection, pneumonia and chest pains. After two weeks, he was sent to a local nursing home but was rushed back to the hospital two days later. He died soon after arriving in the emergency room.

MEETING NEW CRITERIA

"I wish I had kept him in (the hospital longer," says the physician who released Mr. Lane. The doctor, who asked not to be identified, says Mr. Lane would have benefited from further hospitalization because of his poor condition and apparent history of heart problems. But he says the patient was eager to leave and didn't meet the state PRO's new criteria for continued care. The doctor adds that he feared being punished by the PRO if he had kept Mr. Lane in the hospital while those criteria weren't being met.

A spokesman for the Oklahoma PRO says the group's standards are only guidelines and that a doctor can't be punished for keeping a patient too long. But the spokesman says PROs can punish doctors and hospitals for admitting patients who don't meet PRO criteria or for discharging patients too soon.

Indeed, PROs across the country are investigating the practices of hundreds of doctors who allegedly discharged patients too early or violated other PRO standards, says Philip Nathanson, director of the Bureau of Health Standards and Quality for the Health Care Financing Administration, which administers the Medicare program.

But staff members at Henryetta Medical Center say PROs aren't clear about what actions are punishable. And the hospital's administrator, James Clough, questions whether PROs are really concerned about premature discharges. "The government has mandated that the physician will be the executioner," he says, "and told him if you won't use the sword to cut back services from the elderly we will cut off payment from you."

That argument may sound familiar to Carmen Lajoie of Lewiston, Maine. Last September, her husband Antonio, 73, was almost discharged from the Central Maine Medical Center in Lewiston after a three-day stay for dehydration. Hospital personnel explained that Medicare covered only three days of care for his diagnosis.

UNABLE TO WALK

Family members delayed the move, arguing that Mr. Lajoie, who had been unable to eat or get out of bed, needed further care. But on the fifth day, Mr. Lajoie "was told . . . that if he couldn't stand up and be sent home by car, he would have to be sent home in an ambulance—which is how he went," says Elaine Francoeur, the Lajoies' daughter.

Two ambulance attendants were needed to get the 170-pound patient into his bed at home. Mrs. Lajoie says she had no idea how to care for him. In that first week, to try to walk, Mr. Lajoie wrapped his arms around his wife's neck and she pulled him out of bed. During one such effort, both collapsed, and Mr. Lajoie refused to walk again. He was afraid of hurting his wife, and she refused to see a doctor to check for possible injuries.

"She was afraid there would be no one to take care of my father," says Mrs. Fracoeur. At that point, the daughter and her husband took Mr. Lajoie into their home.

Mrs. Lajoie complained to the hospital about her husband's treatment. In January, she received a letter from Frederick Gleason, the doctor who treated him. Referring to the hospital's inability to arrange further care for Mr. Lajoie, Dr. Gleeson wrote: "I feel these decisions were predetermined by the medical care system." Both Dr. Gleeson and hospital administrators decline to discuss the case.

Mr. Lajoie died in March.

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SPECIAL ARTICLE

MEDICARE'S NURSING-HOME BENEFIT: VARIATIONS IN INTERPRETATION

Helen L. Smits, M.D., Judith Feder, Ph.D., and William Scanlon, Ph.D.

Abstract The use of skilled nursing facilities by Medicare beneficiaries as measured in days of care per thousand elderly persons varies considerably from one state to another. To explore the possibility that this variation reflects differences in the administrative interpretation of rules governing coverage, we developed nine hypothetical cases and presented them by telephone to claims reviewers in fiscal intermediaries and professional standards review organizations. Cases were designed to illuminate the reviewers' use of discretion. We observed marked differences both in the reviewers' decisions to cover or not cover patients and in the reasoning behind their decisions. Three of the 18 reviewers decided to cover very few cases, almost half the reviewers decided to cover most of the cases, but not the same ones. In only two cases did the 18 reviewers approach consensus. This variation is a reflection of the complexity of Medicare's coverage rules and its decentralized administration. To reduce variation, we recommend more centralized review with oversight by Medicare's central office rather than by its 10 regional offices. This oversight should include the training of reviewers in a way that focuses on complex cases to improve the consistency of judgment. (N Engl J Med. 1982; 307:855-62.)

MEDICARE coverage in nursing homes has been described as a "broken promise" by Loeser and his colleagues, who cite examples of variation and unpredictability in the administration of the law.[1] The work of Adler and Brown[2] supports this conclusion. They reviewed the records of patients in a single rehabilitation hospital and showed that denials of coverage for rehabilitative hospital care could not be correlated with the patients' clinical conditions.

As shown in Table 1, the actual use of nursing homes by patients who are covered by Medicare varies dramatically from state to state, ranging from a low of 58 days per thousand elderly persons in Mississippi to a high of 691 days per thousand elderly persons in Hawaii. Although many factors, including the availability of beds, are known to influence the use of health-care facilities,[3,4] variability in coverage determinations by Medicare's fiscal agents — the intermediaries — may influence those rates. To explore this possibility we developed a series of nine hypothetical case histories, which we presented to a variety of organizations that have responsibility for reviewing the claims submitted for Medicare payment by skilled-nursing facilities.

Benefit Limitations and the Review Process

The Medicare skilled-nursing benefit is limited by law to patients who have been in the hospital for at least three days and who are admitted within 30 days of discharge from the hospital to a certified skilled-nursing facility.[5-7] The nursing-home admission must be for the condition that led to the hospitalization or one that arose during the hospitalization. Coverage is limited to the period during which the patient is receiving skilled-nursing or rehabilitation services on a daily basis. Furthermore, these must be services that can, as a practical matter, be provided only in a skilled-nursing facility on an inpatient basis.

When a patient requires the daily performance of

From the Urban Institute, 2100 M St., N.W., Washington, DC 20037, where reprint requests should be addressed to Dr. Feder.

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Table 1. Medicare Coverage in Skilled Nursing Facilities — Days per Thousand Persons Age 65 and Over, 1979.*

Hawaii	671.0	South Carolina	401.6	Massachusetts	198.5
Ohio	561.0	Indiana	381.4	Wisconsin	187.4
Kentucky	552.6	Florida	381.4	Connecticut	181.3
North Dakota	548.0	California	378.0	Colorado	172.0
Nevada	533.5	Washington	343.2	Georgia	160.3
		Maryland	340.2	South Dakota	156.0
New Hampshire	512.7	New Jersey	335.6		
Michigan	499.1	Delaware	333.5	Wyoming	149.5
Pennsylvania	475.8	Tennessee	320.0	Minnesota	148.5
Illinois	465.0	Missouri	301.6	Kansas	144.7
North Carolina	463.8			Louisiana	141.0
Montana	459.7	Nebraska	278.2	Oklahoma	118.4
Oregon	425.9	Vermont	275.9	Alaska	110.4
Utah	419.9	Idaho	268.3	Texas	95.3
Alabama	419.8	Maine	264.1	New Mexico	94.1
Rhode Island	414.0	New York	262.9	Arkansas	58.5
		Virginia	243.4	Mississippi	57.9
		District of Columbia	234.1		
		Arizona	230.5	*United States*	326.2
		Iowa	224.1		
		West Virginia	219.7		

*The number of covered days was determined from unpublished data from the Current Utilization Series, Office of Statistics and Data Management, Office of Research, Demonstrations and Statistics, Health Care Financing Administration. Data on the population 65 and over were obtained from the U.S. Bureau of the Census. *Current Population Reports*, Series P-25, No. 796, "Illustrative Projections of State Populations by Age, Race, and Sex: 1975 to 2000." Government Printing Office, Washington, D.C., 1979, Table 6, Series IIB.

certain specific skilled procedures, Medicare coverage is straightforward. Such procedures are listed in the regulations and include intravenous or intramuscular injections, tube feedings, and endotracheal aspiration, and the insertion or irrigation of bladder catheters. The presence or absence of these services in the patient's care is readily observable and requires no discretionary judgment on the part of the claims reviewer.

Other procedures and less specific nursing services, however, are not automatically defined as skilled. For example, the treatment of decubitus ulcer is a skilled and therefore covered service only if the lesion is "extensive" — a condition that must be precisely documented (i.e., the depth and circumference of the sore must be indicated). Medicare's claims processing guidelines allow coverage for nursing observation only of patients whose conditions are unstable. Stability and instability, however, are matters of degree and interpretation. Actual coverage depends heavily on the judgment of the intermediaries' reviewers.

Coverage is also allowed for supervision by a nurse of a patient whose condition is stable, but for whom the performance of an aggregate of typically unskilled services could be medically risky. Coverage is limited to cases "in which there is a significantly high probability, as opposed to a possibility, that complications would arise" in the absence of nursing supervision. In practice, these circumstances seem especially difficult to define.

Coverage based on a daily need for skilled rehabilitation therapies rather than skilled nursing is similarly subject to both restrictions and individual judgment. Coverage guidelines classify physical therapy as a skilled and covered service only when the patient has "restoration potential" — i.e., a potential for "significant" improvement in the condition being treated, within a "reasonable" (and generally predictable) period. The guidelines specify that a person needing "maintenance therapy" may receive only a short period of coverage to allow skilled personnel to establish a course of treatment.

The administration of Medicare's rules for coverage is highly decentralized, involving 80 independent offices of Medicare intermediaries. Until September 30, 1981, when federal requirements changed, 50 professional standards review organizations (PSROs) also reviewed nursing-home claims. Intermediaries and PSROs are supervised by 10 regional offices of the Health Care Financing Administration (HCFA). Interviews with personnel of regional offices, conducted for another segment of this study, indicate that the number of federal personnel available in each region for supervision, their experience and training, and the time given to oversight of this aspect of intermediary performance all vary.

Written guidance for claims review does exist in the form of regulations and of a discussion in the manual that the HCFA provides to intermediaries. More extensive guidelines were developed by the HCFA in 1979-1980 with the expressed intention of making state decisions regarding skilled care under Medicaid more consistent with decisions made by Medicare. These guidelines were widely distributed to states, intermediaries, and PSROs for comment but were never formally issued.

METHODS

To illuminate the precise sources and nature of variations in coverage, we conducted a series of preliminary interviews with nursing-home personnel and staff members of intermediaries and PSROs. Focusing on the areas of decision making they described to us as difficult in these interviews, we developed a series of nine hypothetical cases. The cases were designed to illustrate the use of discretion by reviewers.

We contacted intermediaries and PSROs, informed them that we were conducting an HCFA-sponsored study, and asked them to identify a person who ordinarily reviewed claims. All but one of the organizations we asked to participate did so. Each case was read to the claims reviewer over the telephone. The telephone interviews were conducted by one of us (H.L.S.) or by one of two registered nurses, and reviewers were informed that the cases were hypothetical. The cases were always presented in the same order, with similar cases separated from one another. We asked the reviewer to tell us whether the case would be covered and, if so, for how long. He or she was also asked to describe the factors that were considered when a decision was being made about the case.

Only one reviewer was interviewed at each intermediary or PSRO. Intermediaries were selected on the basis of the number of skilled nursing facility claims reviewed. All the high-volume intermediaries were included in the interviews, and those surveyed handled almost 60 percent of the nursing homes participating in Medicare. We also interviewed reviewers in at least one branch of every commercial firm engaged in the review process. The sample encompassed a broad range of geographic locations, including areas with a relatively high use of Medicare skilled nursing facilities as well as those with a relatively low use. PSROs were selected from among those still performing reviews of skilled-nursing facilities in July 1981.

In all, 18 organizations participated: five Blue Cross plans, seven commercial intermediaries, five PSROs, and the HCFA office (Division of Direct Reimbursement) by which some providers are paid directly. The sample was too small to allow comparison among the different types of intermediaries or between intermediaries and PSROs. In addition, no effort was made to look for intrainstitutional variability or to explore the possibility of variability over time in any one reviewer's responses.

Results

Tables 2 and 3 describe the cases, the regulatory issue that each case was designed to illustrate, and the reviewers' decisions to award or deny coverage. In four of the nine cases rehabilitation was the primary skilled service involved. Skilled nursing was the primary service in the other five. (The order of the cases differs from the order in which they were presented to reviewers.)

The study found that claims reviewers at intermediaries, PSROs, and HCFA's Division of Direct Reimbursement made very different coverage decisions in identical cases. Three of the 18 reviewers awarded coverage for very few cases (three or four). Almost half the reviewers (eight) awarded coverage for most (seven or eight) of the nine cases presented to them. Reviewers who chose to cover or deny similar numbers of cases did not choose to cover or deny the same cases. In only two cases did the 18 reviewers approach consensus in their decisions. In two other cases about half the reviewers approved; the remainder denied. In the remaining five cases only about two thirds of the reviewers made the same decision.

The foregoing description understates the full range of variation in reviewers' decisions. Even when reviewers agreed on awards or denials, they frequently used different rationales for their decisions. Furthermore, whether they agreed or disagreed on coverage, reviewers measured and assessed criteria for coverage — stability, and practical need for institutional care, and restoration potential — in different ways.

Rehabilitation Cases

Case 1 was designed to explore whether physical therapy would be considered a covered, skilled service when the goal of treatment was to maintain, rather than to restore, function. The language in the *Intermediary Manual* is as follows:

> Generally speaking, the repetitive services required to maintain function do not involve the use of complex and sophisticated physical therapy procedures and consequently the judgment and skill of a qualified physical therapist are not required for safety and effectiveness. However, the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program.

This case involved a man confined to a wheelchair who had multiple sclerosis and was described as having acquired progressive contractures of his hands and arms during a period of acute illness in which he received no physical therapy. A vigorous physical-therapy program was then planned to prevent any further deterioration. All but two reviewers would have covered this patient; one denial was based on an assumption that physical therapy at home could be substituted, one reviewer apparently believed that no coverage at all for skilled service should be provided to a patient when the goal of treatment was the prevention of deterioration.

Table 2. Summary of Cases

Case No.	Primary Skilled Service	Brief Description	Regulatory Issue	No. of Reviewers Who Awarded Coverage
1	Rehabilitation	Wheelchair-bound patient with multiple sclerosis and recent contractures of hands and arms	Rehabilitation to prevent deterioration	16
2	Rehabilitation	Unilateral below-the-knee amputation; patient ambulating on crutches	Practical matter	13
3	Rehabilitation	90-year-old patient with left-sided weakness and recent fracture of right arm	Practical matter	8
4	Rehabilitation	Wheelchair-bound woman with new stroke leading to excessive aphasia and upper extremity weakness	Practical matter	17
5	Nursing	Prostate carcinoma with bony metastases, recent stroke with aphasia, difficulty swallowing, and paralysis of right arm and leg	Skilled observation (stable patient)	13
6	Nursing	Totally dependent pa- with decubitus ulcers, four weeks after a severe stroke	Supervision of an aggregate of unskilled services	13
7	Nursing	Psychosis, renal failure, angina, suprapubic catheter in place	Skilled observation (unstable patient)	9
8	Nursing	Metastatic bladder carcinoma with renal failure secondary to obstruction; receiving intramuscular codeine but not every day	Skilled observation and supervision of an aggregate of unskilled services	12
9	Nursing	Uncomplicated recovery from cataract surgery		7

Reasons given for approving coverage included both the need for a physical therapist's involvement at the start of the rehabilitation program and the likelihood that some restoration of function would be achieved.

Table 3. Reviewer Decisions on Coverage of Services for Individual Cases.*

Reviewer		Rehabilitation				Skilled Nursing				Recovery from Cataract Surgery	Total Cases Covered
	Case Number →	1	2	3	4	5	6	7	8	9	
Blue Cross plans and HFCA's Division of Direct Reimbursement	A	Y	Y	Y	Y	N	Y	N	Y	Y	7
	B	N	Y	N	Y	N	Y	Y	Y	N	5
	C	Y	N	Y	Y	Y	I	N	N	N	4
	D	Y	Y	Y	Y	Y	Y	Y	N	Y	8
	E	N	N	N	Y	Y	Y	Y	N	Y	5
	F	Y	I	Y	Y	Y	I	N	Y	N	5
Commercial insurers	G	Y	Y	N	Y	Y	N	N	N	N	4
	H	Y	N	N	Y	Y	Y	Y	Y	Y	7
	I	Y	Y	N	Y	Y	Y	N	N	Y	6
	J	Y	Y	N	Y	Y	Y	Y	Y	N	7
	K	Y	N	N	Y	Y	Y	Y	Y	N	6
	L	Y	Y	N	N	N	I	N	Y	N	3
	M	Y	Y	Y	Y	Y	Y	Y	Y	N	8
PSROs	N	Y	Y	Y	Y	Y	Y	Y	Y	N	8
	O	Y	Y	N	Y	Y	Y	Y	Y	N	7
	P	Y	Y	Y	Y	N	N	N	Y	N	5
	Q	Y	Y	Y	Y	Y	Y	N	N	Y	7
	R	Y	Y	N	Y	N	Y	N	Y	Y	6
No. of reviewers awarding coverage		16	13	8	17	13	13	9	12	7	
No. of reviewers requesting more information			1				3				

*Y denotes yes, N denotes no, and I denotes more information requested.

Almost all the reviewers pointed out, quite correctly, how difficult it was to be certain before physical therapy was begun that there would be no recovery. This observation would probably apply to the therapy of many patients for whom the primary goal of physical therapy was the avoidance of deterioration.

Cases 2, 3, and 4 were all designed to test interpretations of the requirement that the patient "needs or needed on a daily basis ... skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis." Although this requirement is equally applicable to patients needing skilled nursing services, preliminary interviews had identified particular problems in applying the rule when a patient needed rehabilitation services but did not need skilled nursing care.

Cases 2 and 3 were designed after several institutions had informed us that coverage for the rehabilitation of a leg or foot was much more likely than coverage for rehabilitation involving the hands and arms. Both patients needed rehabilitation on a daily basis and both might be expected to have difficulty in obtaining these services as an outpatient. Case 2 was described as a recent amputee, already using crutches and about to learn to walk with a prosthesis; Case 3, as a 90-year-old woman with a severe fracture of her right arm. The 90-year-old was described as having an old left-sided weakness and needing a cane to walk. Although it was not explicitly stated in the description of the case, the fact that the cane would ordinarily be held in the now damaged right hand would make ambulation particularly difficult. Only one reviewer — the only physical therapist interviewed — commented on this point.

In each case extrinsic factors would have an important bearing on the practicality of outpatient therapy as an alternative. For the amputee the fact that she used crutches did not tell the reviewer how mobile and independent she actually was. Similarly, the exact extent of left-sided weakness in the 90-year-old patient with the fractured arm, as well as the degree of incapacity resulting from difficulty in using her cane, would affect her ability to attend and benefit from an outpatient clinic. The availability of outpatient or in-home services and of transportation, the nature of living arrangements, and even the weather and the season would also have an effect on the patient's ability to use outpatient care, as Congress recognized in its definition of coverage.[8] Only two reviewers indicated any interest in any of these issues; both did so only with respect to the amputee's skills on crutches.

A bias in favor of lower-extremity rehabilitation was observed, with 13 reviewers awarding coverage to the amputee and only eight awarding coverage to the woman with the fractured arm. Several reviewers explained their decisions in terms of organizational rules of thumb that call for coverage for all lower-limb amputees or rule out coverage for upper extremities.

Case 4 was a woman permanently confined to a wheelchair who had sustained a new stroke and was in need of physical therapy, occupational therapy, and speech therapy. She was awarded coverage by almost all the reviewers even though her physical therapy was confined to the restoration of function in one good arm. The bias against rehabilitation for an upper extremity thus appeared to have no impact when the practical need for inpatient services was so clear-cut. The one reviewer who denied coverage to the patient did so on different grounds: that the woman's wheelchair-bound base line state was such that she could not be considered to have the necessary restorative potential. This definition of restorative potential as being associated with a high level of independent functioning was not used by other reviewers.

Skilled Nursing Cases

Four of the cases having nursing as the primary skilled service involved were designed to evaluate coverage for the observation, assessment, or supervision of unskilled personnel by a nurse, rather than for the performance of specific skilled procedures. The final case was an uncomplicated one involving a patient who had had cataract surgery.

The manual for intermediaries describes skilled observation as being needed "when the unstabilized condition of the patient requires the skills of a licensed nurse" to detect problems. The term "unstable" does not appear in the discussion of the assessing, planning, and supervising of total care by a skilled nurse, but the concept of clinical instability is implicit in the directive that only those cases be approved in which "there is a significantly high probability . . . that complications would arise" without the skilled supervision.

Two cases — Cases 5 and 6 — were designed to be relatively stable, and two others — Cases 7 and 8 — relatively unstable. Case 8 was also described as being preterminal and was designed to explore the effect on coverage of the fact that a patient was dying.

Stable Cases

Case 5 was described as a 73-year-old man with metastatic cancer of the prostate and a recent severe stroke, which had left him with paralysis of the right arm and leg and difficulty in speaking and swallowing. He needed to be coaxed to take sufficient fluids and needed passive range-of-motion exercises and training in transfers. The physician's orders specifically called for observation both for bone pain and for possible dehydration.

Thirteen reviewers would cover this patient; five would not. Of those who would cover him, only six would do so exclusively on the basis of the need for observation by a skilled nurse. The other seven either considered or focused exclusively on the skilled physical-therapy services needed for training in transfers. One reviewer who awarded him coverage stated that her primary reason for doing so was her belief that the patient might become a candidate for a more vigorous rehabilitation program within the subsequent few weeks. One reviewer who denied coverage also focused on rehabilitation. She believed coverage was inappropriate because of the lack of restorative potential. The others who denied coverage did so because they thought there was no skill involved in the patient's care.

Case 6 was described as a stable "total-care" patient. He was bedridden, needed assistance in all the activities of daily living, had to be turned frequently, and needed passive range-of-motion exercises. Such a patient could be considered to need the skilled supervision of an aggregate of unskilled services. In this instance the man was described as an 88-year-old who had suffered a severe stroke four weeks earlier. He had atrial fibrillation; his heart rate was now under control. When he entered a nursing home he had three bedsores, one of which was healing and two of which were described only as "stage two."

Thirteen reviewers awarded coverage to this patient, two refused coverage, and three asked for more information. All three wanted to know the exact size, depth, and state of the skin ulcers, indicating that they would cover him only if the ulcers needed daily skilled care. This means that they would not cover him for the skilled supervision of an aggregate of unskilled services. Of those who did decide to cover the patient, seven based their determination largely on the skilled-nursing care needed to treat the skin ulcers; only five cited the observation or supervision of the aggregate of unskilled services as the primary reason for coverage.

Unstable Patients

Case 7 was described as a demented patient with severe obstructive uropathy, renal failure, and a heart condition. He had a suprapubic catheter in place. He was considered by the physician-author to be highly unstable because of his markedly abnormal laboratory values, which indicated renal failure; his severe dietary restrictions of protein, salt, and potassium; and the medications aimed at controlling the chemical abnormalities secondary to renal failure. In addition, the nursing staff was requested to observe him closely for symptoms of renal failure, such as nausea and vomiting, to weigh him frequently, and to observe him closely for cardiac pain.

This case revealed an unanticipated criterion applied by reviewers in their interpretations: Almost all viewed the interval between laboratory tests (a month) as an important indication that the patient's condition was stable. Reviewers split evenly on this patient, with nine awarding and nine denying coverage. Reasons for both decisions varied widely. Of those who decided to cover, only seven gave the need for observation as their primary reason. Three cited the combination of psychiatric, renal, and cardiovascular diseases as indicating the need for skilled observation and supervision; four decided that the patient was highly unstable and therefore in need of observation despite the long intervals between laboratory tests. Two who awarded coverage used a skilled nursing procedure — the care of the suprapubic catheter — as their primary reason.

Reasons for not covering were just as diverse. Five reviewers cited the intervals between laboratory tests as evidence that the patient was stable and did not need observation; one supplemented this explanation by noting that no record was kept of intake and output. Another reviewer gave no specific reasons. Two expressed discomfort about covering a psychiatric patient whatever his other medical conditions, and another stated flatly that she preferred to "avoid renal failure" because good hospital and outpatient services were available for such patients.

Case 8, also unstable, was designed to examine whether the patient's terminal state would influence coverage decisions. The patient was described as a 90-year-old woman suffering from metastatic carcinoma of the bladder with associated progressive pelvic pain and rapidly progressive renal failure secondary to obstruction and infection. She also had angina and gout and was at least mildly confused. Her pain medication consisted of two Tylenol tablets with codeine every four hours and injections of codeine for pain as needed. She was described as entering a skilled-nursing facility while "alert and ambulatory" after a 10-day hospital stay for a urinary-tract infection.

Twelve reviewers chose to cover this patient; six did not. Of those who would cover, six cited the need for skilled observation and assessment, whereas the other six focused on the regular administration of an intramuscular pain medication. The patient's terminal state appeared to influence the decisions in favor of coverage; several reviewers noted that coverage was needed because the patient could be expected to need more pain medication in the future. Three of those who did not award her coverage noted that any increase in the frequency of injections would lead them to extend coverage. Only one reviewer observed that the pain medication was less than ideal; she denied coverage because she believed it possible to substitute an oral medication. One other reviewer dealt with the administration of pain medication in the opposite fashion — by covering the patient so long as she was receiving narcotics, regardless of the route.

The final case, Case 9, was designed to assess the policy regarding the coverage of patients recovering from surgery for cataracts. The guidelines are quite ambiguous on this point. Convalescence from cataract surgery, according to the guidelines, "usually does not require skilled nursing." In the next paragraph, however, the second day after cataract surgery is described as "the immediate unstabilized postoperative period during which the possibility of adverse reaction to anesthesia and other aspects of the operative procedure necessitates close skilled monitoring." Our patient was described only as having met his three-day qualifying stay in the hospital and having been transferred to a skilled-nursing facility on the second postoperative day. The cataract surgery was unilateral, and the only medication was some eyedrops.

Seven reviewers extended coverage to this patient; 11 did not. Those who denied coverage considered him to need no skilled services; those who awarded it had a general policy of covering a specified number of days for cataract patients. This number also varied: Four would cover only through the fifth postoperative day, which would mean four days of coverage; two would cover through the sixth postoperative day, which would mean five days of coverage.

SUMMARY OF FINDINGS

This study cannot be taken as evidence that reviewers from different intermediaries will disagree on every patient. Patients receiving clearly defined skilled procedures were not included among the hypothetical cases. The study presents ample evidence, however, that reviewers will disagree on coverage that is contingent on the interpretation of a patient's condition. As a result Medicare coverage for skilled-nursing care is not a clear-cut, predictable benefit from either the physician's or the beneficiary's point of view. Instead, it is highly unpredictable and dependent on criteria that are often implicit, unwritten, and not available for perusal or comment. Differences in criteria and the application of rules of thumb must inevitably lead to disagreement not only on coverage but on the reasoning behind the award or denial.

Rehabilitation Services: A practical matter

When a patient was described as needing multiple rehabilitative services and was also confined to a wheelchair, reviewers agreed that "as a practical matter" the services should be delivered in an institutional setting. When two other patients were described as needing rehabilitation but walking with some difficulty there was much less agreement. Faced with a complex situation, reviewers appeared to retreat to the application of relatively simple rules. Several cited such organizational policies as one granting coverage for inpatient rehabilitation for all patients with recent lower-extremity amputations. No reviewer made a serious attempt to evaluate the factors that would actually affect a patient's ability to receive outpatient or in-home services, such as the availability or transportation or how much actual difficulty the patient had with ambulation. In addition, when two patients were relatively similar in their degree of incapacity there was a bias in favor of covering the one needing rehabilitation for a lower extremity.

Restorative Potential

In general, reviewers tended to reserve judgment on the question of whether a patient had potential for restoration. Despite being told that the primary goal of therapy in Case 1 was "to prevent deterioration," many reviewers noted that some recovery might be possible and that any conclusion regarding restoration should not be drawn until after the rehabilitation program was instituted. In only one instance did the reviewer's independent assessment of restorative potential work against, rather than for, the patient; this was the single reviewer who refused coverage to Case 4 on the grounds that the patient's base-line, wheelchair-bound status was sufficiently poor that restoration was not an appropriate goal.

Skilled Nursing: Observation, assessment, and the supervision of an aggregate of unskilled services

Reviewers were clearly uncomfortable dealing with coverage that was dependent on relatively vague concepts. A common response to the patients requiring complex nursing care was to explore in some detail the need for skilled procedures on an everyday basis; these included the intramuscular medication in Case 8, the dressing changes for the decubitus ulcers in Case 6, and the care of a suprapubic catheter in Case 7. These procedures were cited by many reviewers as the reason for extending coverage even when the service was not required on a daily basis. In Case 5, a number of reviewers deduced an element of skill in the rehabilitative care of the patient and used this as the reason for approving coverage.

Instability

An individual patient's stability or lack of it is an important factor in determining the need for skilled-nursing services. The difficulties inherent in defining instability led the reviewers to use relatively simple rules as the basis for their determinations. The length of the intervals between laboratory tests was frequently used as an indicator of instability; one reviewer was guided by the absence of a record of intake and output. Others relied on the number of medications given or indicated that they would look for frequent changes in medications. Relatively few depended on the degree of abnormality in laboratory test results as an important indicator.

Documentation

Many reviewers noted that documentation can make a great deal of difference in the decision to cover or not cover a patient. All intermediaries request copies of the actual patient records when they think it is necessary. In cases involving rehabilitation services, reviewers indicated that they would look at the physical therapist's notes with special attention to whether the service was performed on a daily basis, whether the physical therapist was actually involved, and whether the patient was making progress. In the case of observation, assessment, and supervision by a skilled nurse, documentation was thought to be very important, but exactly what reviewers would look for varied considerably. One reviewer favored concrete evidence of observation, such as frequent recordings of blood pressure, pulse, and respiration; another would look at the nursing-care plans, searching for frequent change; still another would look in the nursing notes for specific evidence that the patient was being watched closely.

DISCUSSION

In addition to the overall problem of inconsistency in administering what was intended to be a uniform benefit, these cases raise several issues of importance to beneficiaries, physicians, and nursing homes. These issues may be summarized as follows: The duration of coverage is often unpredictable; styles of practice affect coverage; high-quality care may decrease coverage; and unnecessary documentation leads to more coverage.

Unpredictability

Physicians and nursing homes cannot predict how a patient's condition will change after admission to a nursing home. How long a patient will remain unstable or progress toward fulfilling his or her restoration potential will vary from patient to patient. Since Medicare coverage for nursing homes depends on changes in the patient's condition and its duration is not determined in advance, no one knows on admission how long benefits will continue.

Although Medicare's hospital benefits also depend on the patient's condition, Medicare typically covers the full length of a physician-prescribed hospital stay. In contrast, Medicare's nursing-home benefits typically cover only the Medicare-defined skilled-care portion of a stay. Physicians frequently prescribe nursing-home care of some type for some time after Medicare coverage terminates. At some unpredictable and frequently unanticipated point in a nursing-home stay, patients and their families find that they, and not Medicare, are liable for nursing-home bills.

The Influence of Styles of Practice

The addition of skilled-nursing procedures to the care of a nursing-home patient will markedly increase the likelihood that coverage will be granted. A pattern of practice that favors the use of such procedures, such as the administration of heparin rather than warfarin (Coumadin) will therefore lead to increased coverage. Similarly, the use of bandage wrappings on a stump after amputation will lead to coverage; the substitution of ready-made elastic stockings may cause coverage to be discontinued. None of these decisions directly alters the patient's status but they do affect coverage. Coverage dependent on practice patterns increases inconsistency in decisions about patients who have the same degree of disability and the same underlying need for institutional care.

High-Quality Care May Decrease Coverage

Definitions of skilled care that are oriented toward technical procedures have the effect, in certain cases, of reducing coverage for the patient who receives the highest-quality care. Careful control of pain through oral medication would have led to a marked decrease in the number of reviewers willing to cover the preterminal patient described in Case 8; frequent injections of codeine, on the other hand, would have allowed her to be covered. Similarly, the patient in Case 5 would not have been covered by several reviewers so long as painstaking efforts to feed him continued; a nasogastric tube would have guaranteed coverage.

Unnecessary Documentation Leads to More Coverage

Many reviewers examine very specific elements in the records in order to decide about coverage. As a result an institution may find itself in the position of producing patient records that have no purpose other than to guarantee coverage. One reviewer, for example, favored keeping intake and output records as evidence of instability despite the fact that many physicians regard these records as highly inaccurate and therefore useless in most ambulatory patients. The result of such an emphasis on documentation is a marked increase in the amount of time and effort that an institution must spend in preparing material to submit for billing purposes and a shift in focus away from record keeping as a means of communication among those directly responsible for patient care.

POLICY IMPROVEMENTS

Working within existing law, the HCFA should develop an approach to the management of nursing-home benefits that would lead to a much higher degree of consistency in reviewers' decisions about coverage. The handling of claims for skilled-nursing facilities could easily be restricted to a relatively small number of intermediaries. The supervision of claims decisions and all policy guidance on these decisions could be handled in the HCFA's central office rather than in the 10 regions, thus eliminating conflicting instructions about what is in fact national policy. A sophisticated approach to the training process, with heavy emphasis on the use of actual cases and continual comparisons of the decisions made by reviewers in various intermediaries, should enable the staffs of the intermediaries to define areas of disagreement. Policy guidance and training can then be focused on those specific areas.

Written guidelines, the traditional mainstay of federal policy, are one important aspect of such a process. They should be as specific as possible, making a much richer use of illustrative cases than do the current instructions. Loeser and his colleagues have favored the expansion of regulations in an effort to ensure both consistent enforcement of the benefit provisions and public participation in the creation of the guidelines themselves.[1] Formal regulations alone, however, are unlikely to ensure the necessary fine tuning of a system so intimately connected to the complexities of clinical practice. Written materials should nonetheless be made public so that physicians and patients can better understand in advance whether or not payment can be expected for a particular nursing-home stay. Opportunities for public comment on guidelines should also be provided.

Unpredictability in decisions about coverage could be reduced if Medicare intermediaries made firm prospective determinations of coverage. Intermediaries could formally approve coverage for specified periods of time on or shortly after a patient's admission. Patients' cases could be reviewed again when initial coverage periods expired. This approach could be similar to the "presumptive coverage" for specific diagnoses that Congress authorized in 1972 legislation but that Medicare never required of intermediaries.

Further improvement in consistency and predictability, as well as the correction of other problems identified by this study, would require changes in Medicare's underlying legislation. Major changes in coverage could, however, involve a marked increase in the cost of claims for skilled-nursing facilities. An analysis of the potential costs and benefits of such a change is beyond the scope of this paper. Since any immediate legislative change is highly unlikely in an era of intense concern over Medicare costs, administrative action is critical to reducing the high degree of variability in coverage that has been documented in this study.

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The CHAIRMAN. Thank you.

Dr. Knoebel.

STATEMENT OF DR. SUZANNE KNOEBEL

Dr. KNOEBEL. Mr. Chairman, committee members, my name is Suzanne Knoebel. I am the Krannert Professor of Medicine and Associate Director of the Krannert Institute of Cardiology at Indiana University School of Medicine. I am here, however, as a concerned physician, one who finds it difficult to practice quality care today, and I am not unique.

The citizens in the Medicare age group are of particular concern because they are the most vulnerable to potential inequities which may be introduced by medical reimbursement systems which have not yet achieved a balance between cost, quality and access to relevant care, which is true at the present time in the United States.

Let me begin by saying I strongly support health care cost containment as a necessary economic and political goal, one which has become and will become increasingly important as our population ages. I believe we can have economical and efficient medical care while also maintaining our traditional concerns for quality. Increasingly, however, it is becoming a fact of life that the treatment provided patients is shaped by the amount of reimbursement available, medical standards of care are being replaced by price standards.

And under price standards, the incentives are to limit the amount spent per patient, per patient encounter. The goal is short-term cost savings, regardless of the long-term impact.

Much of what you have heard about today, discharging patients early, moving them to nursing homes when that could be prevented are the result of price standards.

And while the level of care provided under price standards may be adequate for the young, the relatively less sick and those with pure or simple diseases, it is increasingly unlikely to be sufficient for the elderly or chronically-ill and those with more severe or complicated disease processes.

Diagnostic and management decisions in the young, and other persons with acute and self-limiting diseases uncomplicated by other health problems, are often well-circumscribed and the reimbursement required for adequate care can be predicted.

What will be required to provide adequate care for the elderly patient, or the one with chronic disease, however, cannot be precisely predicted. Their primary problem may be complicated by many associated diseases.

The factors which need to be considered in order to outline a management plan with the greatest likelihood for an optimal outcome for the elderly, requires that their management be customized.

The costs cannot be averaged or predicted. While, at the present time, there is flexibility within the DRG system of a degree sufficient in some cases, to cover the extra diagnostic or therapeutic costs for those who need it, the trend toward even more stringent reimbursement levels is clear and the tighter the reimbursement rate, the less the flexibility available to allow deviation from averages, and the greater the threat to the elderly patients.

Another problem which relates to the preservation of progress in health care is that reimbursement rates under prospective payment or capped systems are inherently outdated the minute they are made, being based on treatment patterns in effect when the rates were created.

They do not and they cannot provide for new technologies which may improve diagnosis or treatment, but also cost more. This creates a disincentive to diagnose or treat patients in new ways. This has stifling implications on medical progress.

Based on these previously expressed premises that optimal or even adequate care for the elderly may not be achieved with the resources being allowed under cost averaging, it behooves us to look for alternative methods whereby cost to patient outcome can be assessed.

Clearly, a systems approach is necessary. We need to look for specific alternatives for diagnosis and treatment for broad categories of disease. We need to assess the potential impact of a wide range of variables, such as patient age and severity of disease, the accuracy of the tests, the predicted effect of the therapies, predicted responses to stepwise care in nursing homes, and relate these to projected costs.

I believe that formalized decision analysis may provide a methodology for such outcome to cost considerations. Decision analysis begins by defining the problem, assigning probabilities to the potential outcomes if specific pathways are taken, and through simple arithmetic, delineates the decisions with the highest probability of achieving a desired outcome, and at the same time, relates that outcome to the cumulative costs incurred.

I have given you a model in the table which you have been provided. I won't go over it in detail, except to say that what it shows is that in the interest of short-term cost savings, treatment patterns with high probability of having a long-term beneficial effect for the patients are often overlooked and cannot be rationalized under the DRG prepayment system.

The one primarily that is used here is an example from cardiology of the use angioplasty in the acute phases of myocardial infarction, and does relate to an in-hospital situation.

I think you can see that if the mortality were reduced from the 20 percent 1-year mortality for the elderly with a heart attack, down to the potential of 9 percent, we could prevent the necessity of a nursing home for many patients who are there for heart failure and for the complications following their myocardial infarction.

At the present time, with the ratcheting down which is occurring in DRG reimbursement rates, we are not going to be able to provide those therapies, I am afraid. This will create a long-term problem for the elderly.

You can see that the last expensive way to proceed for the short term, in terms of cost per patient, is medical therapy. However, this may not be the best way to proceed in the long run.

This example was used to portray the principle that reimbursement decisions should not be made strictly on the basis of short-term accounting. Medical decisions must be based on resource to outcome considerations.

As cost containment forces choices between cost and outcome, it is only fair that the process be explicit. This, of course, includes considerations for the effects on long-term care.

I would like to conclude by highlighting a few policy implications. First, I realize that the DRG system, as well as other private-sector prepaid plans, will be a fact of life for some time to come.

At the same time, I think the decision analysis approach points up the certain real limitations inherent in such systems. We need more flexibility built into our medical reimbursement system.

We cannot practice medicine in the interests of all patients through adherence to a rigid recipe book approach. Above all, physicians need to be able to utilize new medical and/or financial information without first entering a drawn-out reimbursement appeals process.

We need a more flexible process that makes adequate treatment for older and chronically ill patients possible. And we need quality control, which we do not have in the home health care situation.

How do we achieve that kind of flexibility? While a severity of illness index or an adequate outlier determination process would help, particularly one based on probability analyses of the type you have just seen, and will be in the record, we need also to recognize the needed flexibility is inevitably tied to reimbursement levels generally.

Ratcheting down the overall reimbursement rates for health care or a DRG rate freeze will accelerate the conversion of medical practice from one based on medical norms to one limited to a single, rigid style of practice, one which is dominated by our price and does not take account of individual variability.

We should also show great caution in moving toward new programs utilizing a DRG type of approach. DRG's for physicians, for example. Too many unanswered questions remain about the present program.

We should allow the effects of hospital DRG's on patients and medical progress to become very apparent before proceeding further. The alternative is a very real threat to the effectiveness of our medical system and to patient outcomes.

We need to take steps to promote the utilization and assessment of new technologies or we will never reach the ultimately most cost-effective technology and the least costly ones.

Some short-term provision needs to be made relative to new technologies, so that they can undergo clinical trials and their effect on patient outcome can be shown.

There is no substitute for an informational approach to cost containment. Doctors and Government reimbursement officials need vastly more information about medical costs and the long- and short-term beneficial and detrimental impact of reimbursement decisions.

We need to know more about what benefits are possible at given reimbursement rates, and what benefits we have foregone under reimbursement rates.

We need to know if the tradeoffs make sense for the patients and for society, and we need a system flexible enough to enable us to act on this information. I know of no other way to assure our elderly of security relative to their health care.

The elderly are terribly afraid. We have heard much about that this morning. They should not be.

Thank you.

[The prepared statement of Dr. Knoebel follows:]

PREPARED STATEMENT OF SUZANNE KNOEBEL, M.D., PROFESSOR OF MEDICINE, UNIVERSITY OF INDIANA

My name is Suzanne Knoebel. I am the Herman C. and Ellnora D. Krannert Professor of Medicine and Associate Director of the Krannert Institute of Cardiology at the Indiana University School of Medicine. I am here as a concerned physician.

I appreciate this opportunity to talk with you today about some of the problems I see relative to medical cost-containment plans generally and the DRG system specifically. Citizens in the Medicare age group are of particular concern because they are the most vulnerable to potential inequities which may be introduced by medical reimbursement systems which have not achieved a balance between cost, quality, and access to relevant care as is true at the present time in the United States.

Let me begin by stating that I strongly support health care cost-containment as a necessary economic and political goal, one which has become increasingly important in recent years and one which will become even more important as our population ages. And, I believe we can have economical and efficient medical care while also maintaining our traditional concerns for quality. However, the present DRG system and other prepayment and/or capped systems which have arisen as a result of the impact of the DRG system, create incentives which, if not counterbalanced soon, could force our health care system in very damaging directions under which our traditional goals of optimal patient care and medical progress would be difficult to maintain.

Increasingly, it is becoming a fact of life that the treatment provided patients is shaped by the amount of reimbursement available. Medical standards of care are being replaced by price standards. Under price standards, the incentives are to limit the amount spent per patient per patient encounter. The goal is short term cost savings.

While the level of care provided under price standards may be adequate for the young, the relatively less sick, and those with "pure" or "simple" diseases, it is increasingly unlikely to be sufficient for the elderly, the chronically ill, and those with more severe or complicated disease processes, such as those present in the elderly.

Diagnostic and management decisions in the young and other persons with acute and self-limiting diseases uncomplicated by other health problems are often well circumscribed. Adequate care can usually be provided for an "average" price because the diagnostic and therapeutic requirements can be reasonably precisely predicted.

What will be required to provide adequate care for the elderly patient, or the one with chronic disease, however, can not be precisely predicted. Their primary problem may be complicated by one or more associated diseases. The factors which need to be considered in order to outline a management plan with the greatest likelihood for an optimal outcome for them requires that their management be customized. The costs can not be averaged or predicted. Yet hospitals or nursing homes are reimbursed on the basis of averages. In the interest of their own survival they cannot assume that what they lose on one patient can be made up on the next. Their patient base is not of sufficient magnitude to allow for "averaging" of what might be a population skewed toward a higher cost group. The result is that high cost patients may receive less than adequate care. Furthermore, many diseases of the elderly are chronic. At times, a higher initial expenditure can prevent or ameliorate future expenditures; but, under DRG rates, the higher initial expenditure would not be covered.

While at present there is flexibility within the DRG system of a degree sufficient, in most cases, to cover the extra diagnostic or therapy costs for those who need it, the trend toward ever more stringent reimbursement levels is clear. And the tighter the reimbursement rate, the less the flexibility available to allow deviation from averages and the greater the threat to the elderly patients outcomes.

Another problem, which relates to preservation of progress in health care, is that reimbursement rates under prospective payment or capped systems are inherently anachronistic, being based on treatment patterns in effect when the rates were created. They do not, and cannot, provide for new technologies which may improve diagnoses or treatment but also cost more. This creates a disincentive to diagnose or treat patients in new ways, with stifling implications for medical progress. It would be a profound setback if cost containment created a status quo approach to medical care. We may be moving in that direction.

While the PROPAC process can adjust rates for new technologies, this process is a remedial one, the inevitable slowness of which is certain to limit its impact.

I am confident that the public neither wants nor has mandated us to take unacceptable risks relative to patient outcomes, or to sacrifice medical progress. Clearly, the public still wants improvements in our health care system but, also wants health care delivered more efficiently. These are the goals we must meet.

Based on the previously expressed premise that optimal or even adequate care may not be achieved for many aging or chronically ill patients with the resources allowed under cost-averaging, it behooves us to look for methods whereby costs to patient outcome can be assessed.

We need to know for a given disease condition, complicated or uncomplicated, what kinds of diagnostic tests and medical treatment might be required to assure optimal patient outcome and what this costs. It is equally important to know what appropriate diagnostic tests or treatments can *not* be provided under current cost-containment plans. The public, their representatives, and their physicians need to know specifically what is being given up individually in the name of the cost-containment generally.

Clearly, a systems approach is necessary. We need to look at specific alternatives for diagnosis and treatment for broad categories of disease, assess the potential impact of a wide range of variables, such as patient age and severity of disease, accuracy of the tests, predicted efficacy of therapy, predicted responses to stepwise care, and relate these to projected costs.

I believe formalized decision analysis may provide a methodology for such outcome to cost considerations. Decision analysis begins by defining the problem, assigning probabilities to the potential outcomes if specific pathways are taken, and through simple arithmetic delinates the decision with the highest probability of achieving a desired outcome and, at the same time, relates the outcome to the cumulative costs incurred.

The table provided depicts the utility of formalized clinical decision analysis. The data used are for the purpose of example only but were taken from the literature so they have a basis in scientific inquiry.

MANAGEMENT OF THE EARLY ISCHEMIC PERIOD OF MYOCARDIAL INFARCTION

Strategies	Mortality (percent)		Cost per patient	Cost per life saved
	In hospital	One year		
Medical therapy	15	20	$1,500	([1])
Streptokinase IV	8	16	3,000	37,500
Streptokinase plus angioplasty	8	11	7,000	61,000
Angioplasty	7	9	6,000	41,000
Coronary bypass surgery	5	6	15,000	96,000

[1] Baseline

From the table it may be seen that the predicted mortality for an elderly patient treated medically in the first year following a heart attack may approach 20%. It is the physician's goal to reduce this risk. It may be possible to do so by opening the artery which supplies blood to the threatened part of the heart before the heart muscle dies.

There are several methods which may be used. These are shown on the left of the Table. The predicted in hospital and one year mortalities for each alternative are listed in the second and third columns. The next column shows the average cost per patient and, the final column the cost per life saved.

The obvious and least expensive way to proceed in terms of cost per patient, would be medical therapy; and, there would be some patients for whom this would be the management plan of choice. However, for the short term, because of a significant reduction in in-hospital mortality from 15% to 8%, streptokinase would probably be allowed for the patient early in the course of heart attack. It is unlikely, however, that angioplasty would be allowed (the cost being twice that of streptokinase) even though the long term benefit is significantly greater than that with streptokinase and at little additional cost per life saved. Furthermore, by not allowing angioplasty, the opportunity to significantly decrease mortality would have been permanently missed. Coronary bypass surgery also may reduce long term mortality in this group. In this case, however, the incremental cost per life saved is approximately $300,000. This would be important information relative to resource allocations.

We need to recognize that prospective pricing creates a disincentive to use the angioplasty or surgical approach. The DRG goal is to cut specific patient costs for the short term. There is, thus, a strong incentive to use streptokinase as opposed to angioplasty. While the argument for angioplasty or surgery must be their ultimate long term positive effect on patient outcome, there is no incentive within the DRG system or any system which is simply price driven, to consider this all important factor. Under price driven systems, short term cost reductions are the goal.

The kind of information such decision analyses provides should be of value both for physicians and policymakers. Physicians should find the information of interest because, although physicians have always made decisions based on risk to benefit ratios, such analyses make more precise the process of looking at various strategies and their probable outcomes, and delineate more clearly what the optimal approach might be. It will, of course, always be necessary for physicians to fit their individual patient into the scheme, that is, to refine the probabilities based on the special considerations of each patient. Such analyses provide the physicians with a responsible way to factor costs into the decision process, so that they can make trade-offs between improved medical benefits and added costs, the kind of trade-off doctors will increasingly be forced to face.

In addition, the decision analysis concept offers useful information to policymakers and others involved in reimbursement dollars. Such analyses make it clear that reimbursement decisions should not be strictly accounting matters. Rather, decisions can be based on resource to outcome considerations. Cost-containment forces these choices and it is only fair that the process is explicit.

So far I've been discussing what decision analysis has to offer relative to medicine. Now let me add two caveats. The specific numbers I have presented here are based on the best available information. They are subject to change—as the decision making process itself should change when new information becomes available.

The second point is that the numbers are based on probabilities and do not substitute for specific patient decisions. Nevertheless, such analyses do serve as standards for broad categories of disease diagnosis and treatment and, therefore, at the policy level, can serve to guide policy formulations.

I'd like to conclude by highlighting a few policy implications.

First, I realize that the DRG system as well as other private sector prepayment plans will be a fact of life for some time to come. At the same time, I think the decisions analysis approach points up certain real limitations inherent in such systems. The point is not that DRG rates should be set on the basis of decision analysis. After all, no single methodology is sophisticated enough to take into account all relevant factors in any decision but particularly in medicine where pain, patient preference, and the value of a human life are but a few. Instead, we need more flexibility built into our medical reimbursement system. We cannot practice medicine in the interest of all patients through adherence to a rigid recipe book approach. Above all, physicians need to be able to utilize new medical and/or economic information without first entering a drawn-out reimbursement appeals process. We need a more flexible process that makes adequate treatment for older and more chronically ill patients possible.

How do we achieve that kind of flexibility? While a severity of illness index or an adequate outlier determination process would help, particularly one based on probability analyses of the type you have just seen, we need to also rcognize that the needed flexibility is inevitably tied to reimbursement levels generally. Ratcheting down the overall reimbursement rates for health care or a DRG rate freeze will accelerate the conversion of medical practice from one based on medical norms to one limited to a single rigid style of practice, one which is dominated by price.

We should also show great caution in moving to new programs utilizing a DRG-type of approach, DRGs for physicians for example. Too many unanswered questions remain about the present program. We should allow the effects of hospital DRGs on patients and medical progress to become apparent before proceeding further. The alternative is a very real threat to the effectiveness of our medical system and, above all, to patient outcomes.

Prospective payment systems of all types are based on retrospective data and, thus, a barrier is raised to medical progress. Unless they offer short term cost savings, valuable new techniques and technologies are unlikely to be introduced or allowed to diffuse.

We need to take steps to promote the utilization and assessment of new technologies or we will never reach the ultimately most effective and least costly ones. Some short term provision needs to be made relative to new technologies so they can undergo clinical trials and, if proven effective, be incorporated into reimbursement rate formulas.

There is no substitute for an informational approach to cost-containment. Doctors *and* government reimbursement officials need vastly more information about medical costs and the long and short term beneficial and deterimental impacts of reimbursement decisions.

We need to know more about what benefits are possible at given reimbursement rates and what benefits are foregone. We need to know if the tradeoffs make sense for patients and for society. And we need a system flexible enough to enable us to act on this information.

The CHAIRMAN. Thank you, Doctor. You are the only physician on the panel. I would therefore like to start my questioning with you.

We heard testimony to the effect that pressures have resulted in the early discharge of patients, with the result that they go home still ill, and that in many instances, they get no assistance whatsoever.

Do you agree that this is happening?

Dr. KNOEBEL. Absolutely. I agree.

The CHAIRMAN. You also told the committee that what we need is quality control. Would you elaborate on that as to what kind of quality control we are talking about?

Dr. KNOEBEL. Well, we need quality control of a type that I demonstrated. We need to look at the outcome of our decisions. For every medical decision, there are several alternatives.

The quality alternative is the one that has the highest probability of success, and this needs to be determined by physician groups and system analysts who can assess these processes in a reasonable way.

The CHAIRMAN. But quality control, Doctor, also involves financing. And in a situation where the financing is being reduced, how can then we put in place a system of quality control when we don't have the financing necessary to bring about an adequate program of quality control?

Dr. KNOEBEL. I can't prove it, Mr. Roybal, but I will predict that if some of our practices were now subjected to cost-effective analyses at the type I have shown, that we could show that we are actually spending more than we need to, and what we would save on certain cases, in certain categories of disease, could well be applied to bringing the others up to an adequate level.

The CHAIRMAN. No, I don't doubt that we do need cost containment, that everything possible must be done to bring that under control. On the other hand, we have the other extreme, where reductions are being recommended and being made, such that people are not getting the care that they need, and a great deal of suffering goes on throughout the country.

In fact, Ms. Ladner testified to that fact when her mother was finally found to be eligible for Medicare home health services, but during a particular period there, she was unable to get the care she needed because of these cutbacks.

Now, as a physician, you said that there were many unanswered questions. We agree, and that is one of the reasons why we are holding this hearing. We would like to have some answers.

What would you recommend, Doctor, if you had that one wish? What would you do?

Dr. KNOEBEL. I would like to have someone ask a physician group, in conjunction with a Government group, to sit down and determine what is absolutely medically necessary for quality care of patients under X situation and what would constitute outliers and that would require more than this average care, and I would predict that if that were done, and it would not be terribly difficult with the proper constitution of such a group, I would predict that we would find that we could get the costs reduced even more, while still maintaining quality.

The CHAIRMAN. Well, Dr. Knoebel, about 3 years ago, this committee made just that recommendation, that we get together a cross-section of the medical profession, together with legislators and so forth, and come up with some recommendations as to what can be done to contain costs.

That, of course, has not been done, and I don't know whether it ever will, but that would be a start. We still have the situation where too many of our elderly are suffering the consequences of cutbacks, and somewhere down the line, we are going to have to do something about it.

Now, I have no specific plan as to what can be done, but the truth of the matter is that there are no recommendations being made to this committee as to what we can do.

In fact, testimony before this committee said, well, we don't want to get into the politics of this thing. You have got to get into the politics of this thing.

Dr. KNOEBEL. Absolutely.

The CHAIRMAN. No matter what we do, we are involved in the political process. Even the chair that you sit on, this building, and most anything that is done, took the political process to put it into effect.

We have to then involve ourselves, not as politicians, but as concerned citizens in the political process, and see to it that these problems are taken care of. It is going to be most difficult.

I realize I have taken a longer time than I should, so I am going to start, then, on this other side. I am going to take another 5 minutes. I would like, Ms. Ladner, to inquire about your mother. How is she doing?

Mrs. LADNER. Well, she is much better now. She is home. She has congested heart failure, but she wants to be home, that is the main thing.

The CHAIRMAN. In other words, she would rather be home than be any place else.

Mrs. LADNER. Right.

The CHAIRMAN. And in most instances, I would say that that is what the patient would want.

Mrs. LADNER. Yes.

The CHAIRMAN. The big problem is that we do not have, then, the necessary facilities to make it possible for these people to be home instead of in an institution somewhere.

Mrs. LADNER. Yes.

The CHAIRMAN. And that is what we are talking about today, is it not?

Mrs. **Ladner**. That is right.

The **Chairman**. All right, thank you.

Now, Mr. Walker, you told the committee that the system is just not working. I agree in very general terms. Can you tell the committee whether or not you have other studies that support your findings with regard to the study that you made in Virginia?

Mr. **Walker**. Yes. In addition to the State of Virginia, there has been a study conducted by the Long Term Care Gerontology Center in Dallas, TX, as well as the Area Agency on Aging in Spokane, WA, which surveyed community agencies in the eastern half of that State.

And they support the evidence that we found in our Virginia study, which is a system which is at the breaking point, and beyond that, if you take a look at the number of people that are on waiting lists, who are in desperate need of critical services, the system just is not working, and I concur with you, there is no way to avoid talking politics.

And I would go a step further. There is no way to avoid talking about money for programs for health care persons. It is desperately needed.

And one last point I would like to mention, is that most Congressmen and Congresswomen are very concerned about the number of meals being served in congregate meal sites and the type of support services that are available at congregate meal sites, because in many cases, that is where people, when it comes time for reelection, they find many older persons who vote, and get an opportunity to get by and see them.

Well, I think next time the election rolls around, there will be less sites open, less people at those sites, because we are having to close down sites to move more and more resources to taking care of the acute care needs of the people at their homes.

When reelection time comes around, and politicians go around to these sites and the sites are no longer there or they see a lot less people, maybe they will start visiting the homebound impaired elderly and see how serious these problems are.

The **Chairman**. Thank you.

Ms. Brody, I understand that you are a researcher and gerontologist?

Mrs. **Brody**. Yes, sir.

The **Chairman**. You are an expert in the field, and I wish I had a lot of time to learn something from you. I have, due to the lack of time, one question.

You said that families are the backbone of long-term care. That is a statement that we all agree with. How is the Government threatening the family network and what can we do to provide more support?

Mrs. **Brody**. The threat to the family is that by overburdening the family, by compelling the family to go beyond the limits of human endurance, they themselves experience physical symptoms, stress-related ailments such as ulcers, hypertension and also, severe mental and emotional symptoms.

That kind of pressure, when it is imposed of the family, ultimately increases the costs. As far as what the Government can do with respect to that particular situation—there is virtually nothing being done in the way of focusing on the family to support the family's efforts to go on doing what it wants to do, and what it has been doing.

I am referring to such services as respite care, temporary care, to give families relief. There are some demonstration projects. There are some Medicaid waiver projects, but there is no consistent support for that kind of service.

I am referring to the services such as day care for the impaired aged, also to give the caregivers a break.

There are families that go on year after year, in which the caregiver rarely is able to leave the front door, because they are taking care of an extraordinarily impaired person with Alzheimer's disease who needs someone there every moment.

In addition to those relief services for the family, they need other kinds of relief. They need concrete help in performing some of the care tasks.

For example, an 84-year-old woman finds it very difficult to lift and turn a bed-fast 86 or 87-year-old husband, so that they need help from in-home health services to give them that kind of concrete help, as well as the opportunity to get a break in that care.

There are no consistent programs that focus on the family's need rather than focusing with tunnel vision on the need of the older person for medical services. We really have to broaden our view of what it takes to support the family in its efforts.

The CHAIRMAN. Thank you, Mrs. Brody.

Mr. Yovanovich, many cost containment actions have been taken recently, and some are more threatening than others, that is, threatening to the elderly.

What recommendations do you have, if any, to make to this committee? As you know, this committee is not a legislative committee, it is a fact-finding committee. What we do as individuals is to present legislation, and we have been rather successful in some of the legislation that we have presented.

We have been somewhat successful in getting some of the moneys that we need for Alzheimer's disease, for example, and for other things that are most important.

Do you have any recommendations that you would like to make to this committee now?

Mr. YOVANOVICH. Mr. Chairman, certainly I think some of the recommendations that we have made about current regulation needs to be acted upon at this point. The waiver of liability issue, the cost cap issue, are things that need to be attended to very quickly, in order to preserve the home health system.

I think the recommendation that I would like to make is that we really need to take a look at the long-term care needs of our population, and for years—I have worked in this industry in excess of 20 years—and we have always attempted to encourage the utilization of home health services.

It appears that now that home health services are beginning to be more utilized and to be more effective in dealing with our elderly, we are running into a lot of constraints that are being placed before us by the bureaucrats and by the Health Care Financing Administration in terms of reimbursement issues that allow for the viability and continued viability of home health services.

So I think that there are immediate issues that need to be attended to, and that is certainly to deal with the Health Care Financing Administration and their attempts to limit access by restricting reimbursement to home health agencies, and I think the other issue is to begin to look at the design of the long-term care system that will provide for our elderly and provide for the coordination of benefits to our senior citizens.

Thank you.

The CHAIRMAN. Thank you, sir.

Ms. Struve, I would like to, first of all, congratulate you for being the recipient of the Distinguished Administrator of the Year Award.

Ms. STRUVE. Thank you.

The CHAIRMAN. It is quite an accomplishment, and this award, I understand, comes from the American College of Health Administrators. You are being recognized by your colleagues, and I complement you for that.

But I would like to ask this question. Providers and fiscal intermediaries tell us that HCFA's performance standards for intermediaries are forcing the denial rates up; that is, rates are going up, despite the fact that 30 percent of appeal claims are eventually reversed.

HCFA, of course, denies this. What is your understanding of the situation?

Ms. STRUVE. My understanding, Mr. Chairman, comes from both providers and intermediaries. Statements are really based on high-level executives of the intermediaries. And they claim that HCFA is providing incentives to deny claims.

Likewise, a Midwest intermediary stated that because of their previous poor experience, they were having to reduce monthly their approvals to Medicare beneficiaries.

A provider in that area since May 1984 has had its benefits reduced by 75 percent. Likewise, a large group of nursing homes has seen a reduction of 50 percent in one nursing home, and 28 percent overall.

We believe that the ratio of 5 to 1 is arbitrary. It is not statistically based, and that there should not be incentives to deny coverage that exists under the law.

The CHAIRMAN. Thank you.

The Chair recognizes Mr. Boehlert.

Mr. BOEHLERT. Thank you, Mr. Chairman.

To set the stage for what I am about to say, let me open by saying that I plead guilty to the charge usually leveled by those far to my right on the political spectrum of being a liberal when it comes to voting for spending for programs to meet the special needs of the elderly, not just health care, but nutrition and transportation, you name it.

But I am also convinced that money in and of itself is not the total answer to the problem.

And, Ms. Brody, I was intrigued by your comments that suggest that 80 to 90 percent of the health and social supportive needs of the elderly are being met by the families. And that may be true in the case of those elderly who are having their health and supportive services needs addressed.

But I am concerned about that vast number in our society that are falling through the cracks. My own personal experience from being a county executive, where we had a skilled nursing home facility, was that 90 percent of the patients had relatives within a 25-mile radius of the facility, never had visits from them.

Too many of our Nation's elderly, I think, are either discarded, or ignored, and in our mobile society, their families are halfway across the continent. What do we do to change the attitudes of the American people?

I am one who believes that we have an obligation to all who preceded us, but don't we have a serious national attitudinal problem that you don't find, for example, in the Orient where they not only love and respect, but care for the elderly?

I am willing to vote for the funds that are needed to do the job that has to be done, but I think there is an underlying problem in our society that too many people are just ignoring or turning their backs on the needs of our elderly.

Could you address that, or could comfort me, tell me I am wrong. I would like to be wrong.

Mrs. **Brody**. I hope very much that I can comfort you. What you have just repeated is really the common misunderstanding of the family relationships of older people. It is one body of knowledge that has had consistent findings in the United States and elsewhere; in other words, that families are not abandoning their elderly.

Now, certainly, not all family relationships are close and warm. Some have never been close and warm, and pathology exists in any phase of the life cycle. I picked up the newspaper yesterday, and read the story about a young father who had murdered his 6-month-old child and had sexually abused her before she died, with the agreement of his wife. That is pathology, and it can occur with respect to family relationships in old age as well.

As far as the visits to nursing homes are concerned—staff at nursing homes are often very conscious of the old people who don't get visits, but the national data, not my data, but national data sets show that 90 percent of the people in nursing homes do not have a spouse. Half of them do not have children. The ones who do have children have fewer children than older people outside.

As a matter of fact, Dr. Beth Soto did an analysis of a national data set, and found that each additional child one has reduces the chances of being in an institution in one's old age.

So that the people who are in institutions have fewer social supports, they have fewer potential visitors. The people who can visit them are the adult children, are very often very old and impaired themselves. Studies also show that available family members do visit regularly and are deeply concerned.

In one study that we did, we found that one of the main reasons for going into a nursing home was the death or catastrophic illness in the caregiving generation, not among the old.

Mr. **Boehlert**. If I may, at this point——

Mrs. **Brody**. Please.

Mr. **Boehlert**. Just let me say, I am really deeply concerned about this, and I have spent some time on the subject. Just take my hometown for example. I can name you 48 clubs that are involved in providing all sorts of activities and recreational challenges for our young people, all the service clubs, the Police Benevolent League, the firefighters, and it is all great and I applaud it. The young people are our future.

But I am hard-pressed to find in my community or in most communities service clubs and organizations of this type that are addressing the special needs of the elderly.

Why is the nutrition program so important? It is not just to provide one good balanced meal a day, it is fellowship, it is people that care about each other.

So, Mr. Walker, you and your program, I applaud you for what you are doing, but I think we have a serious problem in our society, and I would love for you to provide for the record any information that you can provide us that will make me a little more comfortable.

But I just see it all the time. We have in our family an 84-year-old grandmother who lives with us. She is not the beneficiary of that relationship, we are, and everyone talks about addressing the needs of the elderly, bringing them out in the community because it is good for the elderly. It is good for society. It is good for the community.

I have got four children. Let me tell you. I don't have a pretty good batting average in terms of enforcing discipline, but grandma does.

I don't know, does anyone else have that same view that we are not doing nearly as well as we should be doing in terms of everyone caring about the elderly and addressing their needs, and not just every time a problem comes up, say, well the Government should appropriate more money.

And I am willing to vote for it, my record proves it.

Mrs. **Brody**. That is a rather different issue. There are many different groups who address the needs or should address the needs of the elderly. I was speaking specifically about family responsibility, which has been firmly established.

Mr. **Boehlert**. Look at the incidence of elderly abuse. They are on the increase dramatically.

Mrs. **Brody**. There again, as I said a few minutes ago, abuse can occur at any stage of the family life cycle, and being old or being a middle-aged person is no guarantee that there will be less pathology than that of a young person. We have to look at that as the extremes of pathology, but we must also look at the mainstream of what families are doing.

Certainly, not one older person should be abused, and we must take steps to prevent that. But we also have to look very carefully at the data. People are calling elder abuse a whole variety of things, ranging from direct physical assaults to an old person saying the family doesn't visit often enough.

That really has to be sorted out carefully, so that we have the hard data and know specifically what can be done about it without using the minority of cases in which there is abuse to say that all families are behaving that way. They are not behaving that way any more than all young parents are beating and abusing their young children.

The CHAIRMAN. The time of the gentleman has expired. I am sorry that I am going to have to cut the hearing a little shorter than anticipated, we have a quorum call and a vote on the floor.

But I would like to take this opportunity to thank the members of the panel. There may be some questions submitted to you, at least one question per person submitted to you. We would appreciate it if you would answer that question to the best of your ability, and submit it to the committee within a period of 3 weeks.

[Written questions were submitted to witnesses, and the following written answers were subsequently received:]

Question submitted to Elaine Brody. With the Federal deficit approaching $200 billion per year, there continues to be pressure to cut spending. On the other side of the coin, do you personally feel that States and local governments are currently doing all they can to provide health care services for the elderly?

Answer. Though states and local governments cannot provide health care services for the elderly without substantial federal assistance, they can do more than they are doing at present. To use the Commonwealth of Pennsylvania as an example—

Reimbursement in Pennsylvania is now $47.01 per day for skilled nursing care and $42.28 for intermediate care (scheduled to go up shortly to $50.14 and $44.11 respectively). Even if the additional $8.00 per day for depreciation and interest is added, those amounts fall far short of the actual cost of $82 per day to this nonprofit facility. Yet the Commonwealth chose to use lottery funds to replace General Fund monies in funding nursing home care rather than to use the lottery funds to improve reimbursement rates. It is obvious that such low rates deny access to nursing homes to the people who need such care the most—that is the "heavy care" medicaid population, most of whom have Alzheimer's disease or a related disorder.

Not only has the Commonwealth reneged on its responsibility to use General Funds for medicaid, but it has used the lottery funds to totally replace its past funding from general revenues for the Department of Aging and all of its programs. In effect, the Commonwealth used lottery funds designated for the aged as a method of transferring its commitment to service this group into a refund for corporate and individual taxpayers.

Pennsylvania is not alone among the states in its failure to care for disadvantaged older people, although the methods used differ from state to state.

Question submitted to Stephen Yovanovich. Do you envision any greater effort to discharge patients sooner in light of a possible freeze on Medicare DRG rates?

Answer. Yes. We do envision a greater incentive for hospitals to discharge patients sooner if there is a freeze on Medicare DRG rates. The reason we see such accelerated discharge practices as a possibility is evidence that hospitals are discharging patients "quicker and sicker" in order to maximize reimbursement under the existing DRG system (see GAO) PEMD-85-8; March 1985 survey by House Aging Committee Task Force on the Rural Elderly; and "Home Care Bears Brunt of DRG System", Hospitals magazine, page 70, June 16, 1985 issue). If this is the preliminary evidence of the situation under the current system, we would expect that hospitals would react even more so if the rates were frozen. Second, a recent survey by the National Council of Community Hospitals, Oak Brook, IL. (see July 5, 1985, Modern Healthcare magazine, page 98) indicates community hospitals are seeing sicker patients in need of more care now compared to three years ago. If hospitals do not feel the DRG rates are adjusted to deal with the situation, it is reasonable to assume they will want to alter their admission and discharge policies to decrease the volume of such patients they handle.

Question submitted to Karen Struve. What is the reason for the fact that 30 percent of SNF patient days are concentrated to just 2 States, New York and California, and 50 percent in 6 States? Aren't the intermediaries in those States functioning under the same conditions as other other 44?

Answer. There are good reasons why thirty percent of the SNF Medicare patient days are in New York and California, while fifty percent are in only six states. Both New York and California have some form of Medicare maximization program, in which providers typically must submit all potential claims to their fiscal intermediaries (FIs) for coverage determinations. In every state, providers submit "claims for payment" when they expect to get coverage, with denials being counted against their waiver of liability. Very few providers, however, choose to submit "no payment billings" when they do not expect to get the claim covered, unless beneficiaries insist upon it. Rather, providers usually will just notify beneficiaries of the denial of the claim, and submit nothing to the FI. In New York state, however, providers must submit all "no payment billings", resulting in more days being covered.

Fifty percent of all SNF Medicare patient days are in only six states not only because of Medicare maximization programs, but because of the wide variety in FI performance throughout the nation on coverage determinations. While each FI is operating under the same statute, their internal manual guidelines and numerous unwritten rules are often very different. It is interesting to note the large percentage of district court determinations, using statutory criteria, that overturn the coverage decisions made by ALJs and FIs, who use their own rules. Thus, as the article in the New England Journal of Medicine illustrates, there is no uniformity in FI coverage decisions.

As our survey indicates, 43 percent of the providers responding stated that their FIs' dicisions had become more restrictive within the past year. This shows how divergent these practices are, and how decisions are made according to very different internal criteria. Intermediaries in these six states are generally making more accurate, predictable decisions than those in other states. Greater uniformity is needed across the country and we should consider requiring providers to submit all vaild potential claims for coverage, without sacrificing their waiver of liability presumption.

Question submitted to Dr. Suzanne Knoebel. You state in your testimony the "medical standards of care are being replaced by price-standards." Is this in fact true? Don't the DRG rates take into account the amount of services that must be provided to a patient?

In your statement, you say that we need to know for a given disease condition "what kinds of diagnostic tests and medical tratment might be required" as well as those which cannot be provided. Are you suggesting that we ought to have a separate DRG system for the elderly?

Answer. The statement that medical standards of care are being replaced by price standards is true. What the statement means is that decisions about how patients are managed are being based with increasing frequency on cost rather than medical requirements for optimal patient outcome for both the long and short terms. DRG rates are based on averages and assumptions about the type of patients who will require care (the case-mix). However, there is no average patient; and, for any particular hospital, there is no assurance of the stability of the distribution of patients between the less ill and the more severely ill. Thus, as these hospitals and other affected health care providers are "at risk" under prepayment or capped systems, their operation also must be based on averages. The result is that while they may have adequate reimbursement to treat patients falling within a substantial portion of the case-mix, they can not apply any "saved" money to the care of the higher cost patients bacause they can be assured that their population for any particular fiscal year will be that which was used to set the case-mix index. Therefore, to avoid financial jeopardy, the patient who may require extra hospital days is discharged when the DRG reimbursement level is reached (or if the high cost is anticipated, the patient may not be admitted at all)—even though the patient's condition is not optimal and care at other sites may not be possible or adequate. Thus, price standards modify medical standards of care. The sicker or older the patient is the more inequitable the system is. More DRGs are not the answer for these would continue to be flawed by the "average" and case-mix concepts. Rather, medical necessity considerations need to be incorporated into the pricing structure. Some reliable measure of severity of illness and/or resource requirements would be of value.

The CHAIRMAN. Thank you very much. The hearing is adjourned.

[Whereupon, at 1:05 p.m., the hearing was adjourned.]

APPENDIX 1

Edward R. Roybal
Chairman, House Select Committee on Aging

H.R. 1970
QUALITY ASSURANCE REFORM ACT OF 1985 (QUARA)

PURPOSE

To improve the health care quality assurance system as it applies to Medicare beneficiaries.

SUMMARY

This bill builds upon the current quality assurance system. It establishes a national level council on quality assurance and requires the Department of Health and Human Services (DHHS), and its contract Peer Review Organizations (PRO), to upgrade the current system as follows:

* Expend at least as much effort and resources for quality assurance as for cost containment;
* Extend quality assurance activities to include all health care services covered by Medicare;
* incorporate local consumer input into oversight of the PROs and into the evaluation and award of PRO contracts;
* Make available "hot-lines" for Medicare health care providers and beneficiaries (or a member of their families) concerned with quality of care problems;
* Involve States in quality assurance activities through the consumer review function; and
* Develop improved methodologies for measuring and assuring quality within and across health care settings. Conduct studies to analyze the impact of cost containment on health care quality, and to examine the desirability and feasibility of extending the quality assurance system to include all patients and payers.

PROVISIONS

Increased PRO Emphasis on Quality Assurance

Under existing law and DHHS administration of that law, PROs are concentrating most of their effort on utilization review for the purpose of containing costs.

This bill requires DHHS to award, administer, and evaluate its PRO contracts under the stipulation that at least one-half of the PRO's level of effort is for the purpose of quality assurance as of October 1, 1986.

MEDICARE QUALITY ASSURANCE REFORM ACT OF 1985
Edward R. Roybal

Extension of Quality Assurance for All Medicare Covered Services

Under existing law, the PROs do have the authority to conduct quality assurance for all Medicare covered health care services including hospital services. However, DHHS is administering the program in such a way as to limit PRO review to hospital care.

This bill requires the DHHS and its contract PROs to conduct quality assurance activities on all Medicare covered health care providers including hospitals, physician offices, nursing homes, home health agencies, and hospices. The level of PRO effort expended on each type of provider is in proportion to the Medicare expenditures for this type of provider. Similarly, membership on PRO boards reflects the range of health care providers reviewed by the PRO. DHHS is required to make available to PROs such data as is necessary to carry out their expanded role. This requirement is to be phased in as early as is feasible and no later than April 1, 1988.

Quality Assurance "Hot-line"

Under existing law, the Medicare beneficiary has virtually no place to turn when faced with health care quality problems such as an early hospital discharge.

This bill requires PROs to have a 24-hour hot-line for receiving questions and complaints from Medicare providers, beneficiaries and interested parties concerning health care quality problems. The CAB has access to the information received from the hot-line as long as it does not identify individual beneficiaries or health care providers. PROs are required to assist in the resolution of any legitimate quality related problems.

DHHS, in coordination with each PRO, shall provide Medicare beneficiaries with the hot-line number for their PRO in a way that can be easily attached to their Medicare card.

Local Consumer Advisory Board

Under existing law, consumer input into the quality assurance system is not encouraged. Some PROs are beginning to experiment with consumer participation through the PRO's board or through consumer advisory boards.

This bill requires each PRO to have a Consumer Advisory Board (CAB) by October 1, 1986 which conducts ongoing oversight of the PROs, provides input into the award and evaluation of PRO contracts, and can receive input from Medicare beneficiaries and other interested parties. The CAB and the PRO are responsible for educating Medicare beneficiaries on quality assurance and on the availability of assistance from the PRO and other agencies. With the exception of the educational function, the CAB is not to be involved in the day-to-day operations of the PRO. The PRO makes available to the CAB such information as is necessary to carry out the CAB function. The CAB does not have access to the PRO's review information on either individual beneficiaries or individual health care providers.

The CAB is required to prepare an annual report on the PRO's performance and submit that report to the respective Governor(s), to the national Council on Quality Assurance, and to DHHS. DHHS is required to utilize CAB input in its decisions to award PRO contracts.

The CAB consists of 5-7 volunteer members appointed by the respective Governor of the state covered by the PRO and representing organizations of the elderly and disabled. As PRO review expands to include other consumers, the number of CAB members may be increased proportionately as long as Medicare beneficiaries continue to represent at least one-third of the members. Limited staff support for the CAB is to be provided by the PRO as is necessary to carry out the CAB's functions.

MEDICARE QUALITY ASSURANCE REFORM ACT OF 1985

Edward R. Roybal

National Council on Quality Assurance

Under existing law, oversight is conducted by DHHS, and, to a limited extent, the Congress.

This bill requires the establishment of a national Council on Quality Assurance (CQA) by April 1, 1986. The Council's function is to provide oversight on the operations of the quality assurance system and to make recommendations to the DHHS Secretary and the Congress for its improvement. Its oversight function includes the review of the administration of quality assurance by DHHS, the overall performance of the PROs, reports of the Consumer Advisory Boards, quality assurance studies and methodologies developed by DHHS and others, the data needs of the PROs and input from interested parties. DHHS is required to provide such information as is needed by CQA to carry out its responsibilities. Based upon these reviews, the Council is to make recommendations annually for improving quality assurance to the DHHS Secretary and to the Congress. DHHS is required to take into account CQA input in its administration of the PRO program.

The Director of the Congressional Office of Technology Assessment (OTA) will provide for the appointment of the nine member Council consisting of equal numbers of health care providers, representatives of the elderly and disabled, and experts in quality assurance. As PRO review expands to include other consumers, the number of Council members may be increased proportionately as long as Medicare beneficiaries continue to represent at least one-fifth of the members. Subject to the review by OTA, the Council may employ and fix compensation for up to 10 persons as necessary to carry out these functions.

Studies and Reports

DHHS shall prepare an annual report which assesses the performance of the quality assurance system and addresses the recommendations of the CQA and the concerns and recommendations of the CABs. DHHS shall submit the annual report to Congress by October 1.

DHHS shall analyze the impact which the Prospective Payment System (PPS) and limitations on hospital Diagnostic Related Grouping (DRG) payments have had on health care quality and submit a report to Congress by July 1, 1986.

DHHS shall conduct studies on and develop improved methodologies for quality assessment and assurance for health care services including hospital, physician, nursing home, home health services, and hospice services. DHHS shall submit an annual report to Congress by October 1 on the progress toward developing such methodologies.

DHHS shall conduct a study of the feasibility of expanding the PRO-based quality assurance system to all payers, all patients, and all health care providers and submit a report on the feasibility study to Congress by October 1, 1987.

Funding

As compared to current law and adjusted for inflation, the funding level for the PRO program is increased by 30 percent in 1986 (first year of implementation), by 40 percent in 1987, and by 50 percent in 1988 and in subsequent years. The funding for the CQA and the PROs program will be made from the Medicare Trust Funds. The relative proportions funded from the Part A and Part B Trust Funds are in proportion to the total health care benefit payments respectively of Part A and Part B.

APPENDIX 2

ASHA American Speech-Language-Hearing Association
10801 Rockville Pike • Rockville, Maryland 20852 • (301) 897-5700 (Voice or TTY)

July 12, 1985

Edward R. Roybal, Chairman
Select Committee on Aging
United States House of Representatives
712 House Annex One
Washington, D.C. 20510

Dear Congressman Roybal:

The American Speech-Language-Hearing Association welcomes this opportunity to submit a statement to accompany your hearings on July 9, 1985, regarding the effects of health care cost containment. For the reasons given below, we believe that health care cost containment efforts by Medicare fiscal intermediaries and carriers has, in some instances, inappropriately led to the elimination of vitally necessary rehabilitation services.

The American Speech-Language-Hearing Association is comprised of over 43,000 speech-language pathologists and audiologists. A large number of our members provide services to Medicare beneficiaries in hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, and comprehensive outpatient rehabilitation facilities. Most of these beneficiaries are stroke victims who have lost their ability to speak or to use language (aphasia) following a stroke or similar cerebral vascular accident. Other Medicare beneficiaries receive speech-language pathology services following the removal of their voice box (laryngectomy) or because of problems with their voice, (e.g., vocal polyps). Coverage for speech-language pathology was established in 1972 and was amended in 1980.

In recent months, our members have reported increasing inefficiency by intermediaries and carriers and arbitrary decisions regarding speech-language pathology services. In their effort to control cost, it appears that fiscal intermediaries and carriers are engaging in activities which are unsupportable and which are discouraging providers from participating in the Medicare program.

Current Problems

Speech-language pathologists across the country are reporting increased difficulties with Medicare. This statement relies on frequent communication with our members and also on a survey conducted of directors of speech and hearing hospital departments and clinics at a recent meeting in Chicago, Illinois. That meeting reinforced our perception that the Medicare program is becoming a much more difficult program to work with than it has been in the past several years. For example, 43% of the respondents to our survey at the conference reported that Medicare has presented more difficulties in payment than it has previously. These specific problems included an increase in denials for service (34%) and an increase in the use of restrictive guidelines (28%).

The rise in the use of guidelines by Medicare intermediaries on a local level has been increasing dramatically. There are national speech-language pathology guidelines developed by HCFA and published in 1980. While these guidelines require that intermediaries who do wish to establish local guidelines should consult with ASHA or with the state speech and hearing association, little consultation has actually occurred. The guidelines issued by Blue Cross-Blue Shield of Utah are one of the most arbitrary and capricious guidelines that has come to our attention (attached). By setting exact amounts of treatment sessions that can be provided for different diagnoses, it negates Congress' clear statutory requirement that the physician or speech-language pathologist establish the plan of treatment providing for the frequency, intensity and duration of services (P.L. 96-499). Furthermore, even though it is described as a "screen", our members believe, based on conversations with medical review personnel at the intermediary, that it will operate as a cap. This 'guideline' was developed over the objection of the Utah Speech, Language and Hearing Association which pointed to the lack of any research or scientific basis for the limits established.

Other guidelines or policies have been put into place which are arbitrary and oftentimes simply ridiculous. For example, Blue Cross-Blue Shield of Indiana, in its administration of the Medicare program, will not pay for an evaluation of a patient referred because of a suspected speech-language problem unless treatment services are provided to that patient. The ability to predict that a particular patient will need speech-language pathology services before doing an evaluation is known only to the officials of Indiana Blue Cross-Blue Shield not to the professionals who render the services. Blue Cross-Blue Shield of Indiana also will not disclose who is acting as their consultant reviewing speech-language pathology claims for reasons of "personal privacy." This has meant no clear communication between BC/BS and the professional community on crucial issues of who will receive services. Sometimes claims are denied for lack of documentation which is in fact present, such as a referral from a physician. Sometimes claims denied by one intermediary are paid for by another when a contractual change shifts intermediaries.

Blue Cross-Blue Shield of Oregon appears to demand that actual improvement in speech be documented in every visit even when such a demand is clearly unreasonable for neurologically impaired patients. When our members raise questions to the fiscal intermediaries and carriers about these guidelines, they are told that it will not be worth their while to appeal since the process is run by the same people who established the guidelines. This obviously reduces any feeling of legitimacy that the Medicare appeal process under Part B was designed to provide.

When members do utilize the appeal process, further problems present themselves. First, when the carrier or intermediary appoints the hearing officer, the appearance of a conflict of interest is one that causes a lack of confidence. Attending one such hearing in Portland, Oregon, it was clear to me that the hearing officer was a retiree of Blue Cross-Blue Shield and was very well known to the individuals on the staff who denied the claims. Hearing officers are reported to us as actively helping to find any item in the documentation which would support the reasons for the denial as opposed to an even-handed analysis of both sides of the issue. Our members who have gone through this process do not understand how a hearing officer who depends on the carrier for work cannot be biased toward the carrier, much more so for a person actively employed by the carrier.

Second, more and more it appears intermediaries are delaying responding to claims filed for four or five months. Letters appealing denials may go unanswered for many more months. Some intermediaries are now employing "mailbacks" which is simply mailing back the claim without formally denying it. This is occurring with Blue Cross of California and Blue Cross-Blue Shield of Indiana.

Third, some intermediaries are giving out wrong information regarding Medicare policies. For example, members have been told that they cannot represent the beneficiary in a Part B appeal when the HCFA policy on this subject is only to Part A appeals. Other members have been misinformed that they cannot appeal denied claims which were paid under the waiver of liability when the federal regulations do provide that they can.

Effects on Services to Beneficiaries

The increased use of arbitrary guidelines, inconsistent and arbitrary denials, excessive paperwork and misinformation exacerbate professionals. Many of these are frustrated by these problems. A small number of denials which take a long, time-consuming process to resolve seriously hurts a professional's financial ability to continue in the Medicare program. For services provided through a skilled nursing facility or a home health agency, the effects are the same. Even a few claims paid under the waiver of liability create a response in the mind of the administrator that services should be dropped which threaten the provider's waiver of liability status. This sequence has in fact resulted in loss of contracts, loss of jobs and, therefore, loss of services to beneficiaries.

The Prospective Payment System also presents special problems in the provision of services to Medicare beneficiaries. In a recent edition of Health Span (Vol. 2, No. 5, May 1985, attached), Richard Kusserow, the Inspector General of the Department of Health and Human Services, is quoted as indicating that a certain nursing home in Texas, paid prospectively, failed to deliver services it promised and patients died as a result. He goes on to state that this case involved no fraud against the government or false claims. Similar situations were brought to our attention after the introduction of the Prospective Payment System for hospitals. Although there may be only one or two incidents of this type, it is important for the Committee to realize that the Prospective Payment System does allow for a facility to reduce services on which its rates are based to the detriment of the Medicare beneficiary. The beneficiary may then have no opportunity whatsoever to know that the services to which he or she is entitled are not being provided nor can the beneficiary appeal the denial of such services. In addition, under the Medicare Prospective Payment System for hospital inpatients, Medicare beneficiaries may not even be able to pay privately for the services that they wish to receive while in the hospital when the services are promised under Medicare but not delivered. When decisions are made under Part A, the beneficiary loses their freedom to choose who shall represent them since HCFA unilaterally decided that providers cannot represent beneficiaries in Part A cases.

Recommendations

There is no right without a remedy, but for many Medicare beneficiaries, the right to services for which they have paid under Medicare has no effective remedy. The system as presently designed, especially under Part B, is almost totally biased in favor of the fiscal intermediaries and carriers. It appears that the pressure to control cost has become so powerful that intermediaries and carriers are resorting to any arbitrary policy in an effort to reduce cost to the program. The health benefits promised to Medicare beneficiaries are simply too important to be left to the whims of intermediaries under such fiscal pressure. Increasingly, speech-language pathologists avoid the extensive and often repetitive paperwork and confusion which accompany provision of services to Medicare beneficiaries. Our members have the ability to look to many settings for satisfying professional practice. When difficulty with Medicare become so great, they will do that. Unfortunately, the true victim is the Medicare beneficiary who has paid both taxes and a supplemental premium believing that Medicare will deliver on its commitment to provide speech-language pathology services when the beneficiary needs them. When that individual suffers a stroke or other incapacitating accident, the services are likely not to be there for him or her due to the tactics of some fiscal intermediaries and carriers.

In the past, the lack of judicial review for Medicare decisions under Part B has been explained on the grounds that such would overburden the courts and would involve small amounts of money. This is a simplistic view of the problem. It is not the amounts of money involved that are significant; as a matter of fact, sometimes the amounts of money involved are quite substantial. The problem is that there are individuals whose medical condition requires the receipt of services for they have paid taxes or premiums and that those individuals have no recourse when those services are denied except to the entity which denied the services the first time.

We urge that the House Select Committee on Aging move quickly to encourage congressional enactment of reforms which will provide for a meaningful process by which carrier and intermediary decisions under Part A and B can be quickly resolved in an atmosphere free of the appearance or reality of bias. In this process, providers need to be able to represent the claims of beneficiaries when so appointed. Providers in these cases are truly the insurers of the services to the Medicare beneficiary and they should have a right to appeal an adverse decision, especially when the beneficiary does not have any health or financial interest in pursuing the appeal. The federal courts must be opened to appeals from intermediaries under Part B. So-called 'technical denials' which interpret terms such as 'skilled level of care' or 'homebound' need an avenue for resolution. We believe that the legislation introduced by Representative Ron Wyden, HR 2864, the Fair Medicare Appeals Act of 1985, goes far in rectifying these problems and should be enacted quickly.

The American Speech-Language-Hearing Association appreciates this opportunity to be heard on this important matter and urges that the Committee act quickly to rectify what is an increasingly arbitrary and capricious system.

Sincerely,

Morgan Downey, Esq.
Director
Governmental Affairs Department

Enclosures

SPEECH THERAPY SCREENING CRITERIA

Section VII
92507.3

Diagnosis	Intensity	Treatments Allowed
Aphasia, Child	3 x week	30
Amyotrophic Lateral Sclerosis (ALS)	3 x week	12
Articulation, functional	3 x week	30
Aural Rehabilitation		
Children		
- Unilateral	3 x week	20
- Bilateral	3 x week	30
Adults		
- Unilateral	-	0
- Bilateral		
Less than 60 decibels (db)	-	Refer MR
More than 60 decibels (db)	-	10
Brain Tumor, postoperative	3 x week	40
Carcinoma		
- Larynx, postlaryngectomy	3 x week	40
- Phorynx	3 x week	40
- Tongue	3 x week	40
Cerebral Vascular Accident (CVA), acute	3 x week	40
Cerebral Vascular Hemorrhage, acute	3 x week	40
Cerebral Thrombosis, acute	3 x week	40
Cleft Lip	-	Refer MR
Cleft Palate	3 x week	30
Cerebral Palsy		
- Child	3 x week	40
- Adult	-	6
Developmental Speech and Language disorders	3 x week	30
Head Injury	3 x week	40
Huntington's Chorea (Medicare only)	3 x week	12
Laryngeal		
- Fracture	3 x week	20

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- Paralysis	3 x week	30
Macrognathism		
Mental Retardation (aphasia or dysarthria - Medicare only)	Initial visit for evaluation to determine level of functioning prior to implementation of a restoration speech therapy program.	
Micrognathism		
Multiple Sclerosis	3 x week	18
Paralysis Agitans (Parkinsonism)	3 x week	6
Stuttering, Stammering	3 x week	30
Vocal Cord Pathology		
- Polyps	3 x week	12
- Paralysis	3 x week	30

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National HomeCaring Council Serving the Homemaker-Home Health Aide Field

235 Park Avenue South • New York, N.Y. 10003 • (212) 674-4990

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[illegible] Farrell

July 11, 1985

Honorable Edward Roybal
Chairman, Select Committee on Aging
U.S. House of Representatives
712 House Office Building, Annex I
Washington, DC 20515

Dear Chairman Roybal:

The National HomeCaring Council appreciates your recent efforts to take the Department of Health and Human Services to task in their most recent effort to put a further squeeze on Medicare beneficiaries and Home Care agencies.

The recent increase in denial rates by Medicare for Home Care services is unthinkable, especially when the prospective payment system imposed gives incentive to hospitals to discharge patients earlier and sicker than before. More people are in need of Home Care for this reason alone, and some of these patients need an advanced degree of care.

We appreciate your efforts and encourage your further support.

Please make this letter part of your July 9, 1985, hearing record.

Sincerely,

Jeanne Farrell

Jeanne Farrell

A nonprofit
national
standard-setting
organization

VICTOR ATIYEH
GOVERNOR

Department of Human Resources
SENIOR SERVICES DIVISION
313 PUBLIC SERVICE BUILDING, SALEM, OREGON 97310

July 8, 1985

The Honorable Edward R. Roybal, Chairman
House Select Committee on Aging
House Office Building Annex #1
Room 712
Washington, D.C. 20515

Dear Representative Roybal:

I am transmitting for your committee's attention the results of a survey which my agency recently conducted of all State Medicaid Directors and all State Agency on Aging Directors. The survey pertains to Home and Community Based Care Waivers provided under the Medicaid Program.

The intent of these waivers was to utilize Medicaid funding for the provision of home and community based services to individuals (primarily the elderly) whose impairment levels were such that they would normally qualify for care in a nursing home. For years, state administrators of programs for the elderly, as well as Medicaid Administrators, had complained that the Medicaid program provided few, if any, incentives to the states to provide care for individuals in a home-like atmosphere while providing almost unlimited incentives to send them to nursing homes where costs had been rising at rates well above the Consumer Price Index for several years. These incentives existed in spite of the fact that considerable data existed indicating that most persons being sent to nursing homes suffered from functional, not medical disorders and could be cared for in a nonmedical environment at a lower cost.

The legislation sponsored by Congressman Waxman, which provided the states the authority to offer these services (Section 2176 of the Omnibus Reconcilliation Act of 1981), was hailed by the states and by organizations representing the elderly and disabled as a major breakthrough. In authorizing the legislation, Congress was not attempting to find a way to save money at the expense of the elderly; however, it did not want more money expended in the aggregate through the Medicaid Program than would have been spent had waivers not been granted.

AN EQUAL OPPORTUNITY EMPLOYER

Oregon was the first state to seek a waiver under this Act and by nearly any indicator one would care to use, its first three-year waiver was a success. For instance, we reduced the number of individual Medicaid funded nursing home recipients from 13,188 to 12,387. Had the growth patterns which preceded the waiver period continued, we would have served 15,243 individuals in nursing homes. We accomplished this by diverting from nursing home care approximately 4,200 individuals and by relocating approximately 3,110 individuals from nursing facility placements to community settings. Even though it was not the intent of the waivers to save state and federal money, we were able to accomplish substantial savings (about $7.5 million) in federal dollars (and 12 million total dollars) during those three years.

We were, therefore, very surprised when, as we sought to renew our waiver in mid-1984, that the Health Care Financing Administration and the Office of Management and Budget appeared to be placing roadblocks in the way of those states, including ours, which were seeking to renew their waivers.

Our agency spent the next seven months working almost night and day obtaining a renewal of its original waiver. I will not go into detail in this letter about the efforts which were expended to finally obtain approval of its waiver, instead, I have attached testimony which I submitted to Congressman Waxman's subcommittee on Health and the Environment on that subject. It also deals with regulations which HCFA promulgated in final form on March 13, 1985. Those regulations have taken away many of the incentives Congress had given the states to provide home and community based care through Title XIX.

As I mentioned, my main purpose in writing is to convey the results of our survey which was conducted this spring. As you can see, the people who are administering home and community based care waivers are almost totally dissatisfied with the present situation with respect to the waivers. Ninety three percent of them said "no" when asked "are you satisfied with the present situation?" However, the main point of interest for me in this survey is what my cohorts see as a long-term solution to this present situation. Most of them, especially state Medicaid Directors, would like to see the waivers (which must now be renewed every three years) removed from a waiver status and made an opitonal service under Medicaid.

Looking down the road even further, a significant number would like to see Congress address the subject of long-term care through a separate piece of legislation which would remove home and community services from Medicaid law entirely and fund them through a new Title to the Social Security Act. No new funding should be required to do this for services to the presently eligible Medicaid population.

Funding could be shifted from Medicaid to a new Title to accomplish this end. I would hope that your committee might take a close look at this alternative as direction for the future.

Sincerely,

Richard C. Ladd

Richard C. Ladd
Administrator

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Enclosures

Attachment #1

SURVEY ON
HOME AND COMMUNITY-BASED WAIVERS

The State of Oregon sent a questionnaire survey to each State Medicaid Director and to each State Aging Director regarding Home and Community-Based Waivers. The preliminary results are as follows:

A. General

99 surveys were sent
45 responses were received (45.5%)
34 states responded (68%)
27 Medicaid Directors responded
20 Aging Directors responded
12 states had both Medicaid and Aging Directors respond (two states had both Medicaid and Aging responses incorporated into one response jointly).

B. Specific

1. To the question "Are you satisfied with present situation?".

2 states said yes (6.2%)
32 states said no (94.1%)

2. States were asked to rank four different options to the present situation.

Option (a). Rewrite of present waiver legislation (Section 1915(c) of the Social Security Act).

6 respondents ranked this first.
12 respondents ranked this second.
9 respondents ranked this third.
14 respondents ranked this fourth.
4 respondents did not rank this option.

Average rank was 2.76.

Option (b). Add Home and Community-Based Waivers as an optional service under Title XIX:

23 respondents ranked this first.
10 respondents ranked this second.
6 respondents ranked this third.
3 respondents ranked this fourth.
3 respondents did not rank this option.

Average rank was 1.74.

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Option (c). Block Grant all long-term care funding to the states:

7 respondents ranked this first.
10 respondents ranked this second.
10 respondents ranked this third.
15 respondents ranked this fourth.
3 respondents did not rank this option.

Average rank was 2.79.

Option (d). Create a new title to the Social Security Act which would include all long-term care funding.

9 respondents ranked this first.
11 respondents ranked this second.
13 respondents ranked this third.
10 respondents ranked this fourth.
2 respondents did not rank this option.

Average rank was 2.56.

A few states ranked more than one option the same. Almost half of those responding, however, choose option (b) (add Home and Community-Based Waivers as an optional service under Title XIX) as their first choice. The other three choices seem about even, with option (d) (creating a new title to the Social Security Act) slightly more popular than the other two.

Many respondents added comments that indicated they liked option (c) or (d), but were very fearful that these options would lead to reduced funding from the federal government (as has been the case with the Social Services Block Grants).

A few states indicated that option (b) was a good short-term solution, but that option (d) should be the long-term choice.

3. States were also asked if there was another option to the present waiver situation that would be attractive to them, and how they would rank that option.

16 respondents listed other options.
13 respondents ranked this other option first.
2 respondents ranked this other option second.
1 respondent ranked this other option third.

More specifically:

2 states indicated satisfaction with the present situation.

2 states indicated that moving waivers to optional services under Title XIX was desirable, but that the scope of optional services should be reduced.

3 states indicated that long-term care should be incorporated into either Title XX (Social Services Block Grant) or the Older Americans Act, and transferred to the Office of Human Development Sevices (OHDS).

3 states supported a two-stage approach with either a block grant or optional service status first, with a new title for long-term care later.

1 state suggested moving long-term care to Medicare.

1 state suggested restricting OMB activities in long-term care.

1 state supported a new title but with assurances of a wide range of services allowable.

1 state suggested we communicate to HCFA our displeasure with the March 13th regulations.

1 state supported any action which allowed more flexibility.

1 state indicated that after a three-year waiver period, long-term care became a part of the State Title XIX plan (if proven cost effective).

4. Finally, states were asked if they would be willing to provide testimony if hearings were held on Home and Community-Based Waivers. Thirty-one (68.9%) respondents indicated they would be willing to do so.

ATTACHMENT #2

STATEMENT FOR THE RECORD ON HOME AND COMMUNITY BASED WAIVERS

by
Richard Ladd, Administrator
STATE OF OREGON
-SENIOR SERVICES DIVISION

for

HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

The Honorable Henry Waxman, Chairman

Mr. Chairman:

I am submitting this testimony subsequent to a verbal presentation which I made to the committee on June 25, 1985. This testimony goes into more detail and it deals with items which are more of a technical nature than those which I provided verbally. It also deals more specifically with the two problem areas around which you had solicited testimony on June 25. Those areas, as I understand it, are:

1. The problems the states have had in working with the Health Care Financing Administration in implementing the waivers; and

2. Concerns we have with the Health Care Financing Administration's March 13, 1985 regulations.

My testimony deals with these two subjects in the order mentioned above. In addition to that, I will present some specific proposals regarding the action I feel Congress should take in the long and short run to deal with the long-term care of this country's aged and disabled population which is at risk of institutionalization.

I. Problems in Implementing the Waiver

Perhaps, Mr. Chairman, I can best illustrate the problems Oregon has had implementing its waivers by reviewing the sequence of events which has occurred over the past year as our state attempted to renew its first home and community based care waiver. Oregon was the first state granted a waiver under Section 1915(c) of the act. We submitted our first application for a comprehensive waiver shortly after Section 2176 of the Omnibus Reconcilliation Bill was passed. That application was quickly approved by the Health Care Financing Administration. Our waiver served aged, blind and disabled as well as mentally retarded and mentally ill individuals. Prior to obtaining approval for the waiver, Oregon had conducted several years of research in cooperation with the Health Care Financing Administration and the Administration on Aging on the subject of long-term care and how to obtain a balance between nursing homes and community based services that would best meet the needs of the elderly and the disabled.

The waiver had been very successful in nearly all respects as far as we could determine. During these first three years of our initial waiver, we reduced the number of individual Medicaid funded nursing home recipients from 13,188 to 12,387. Had the growth patterns which preceded the waiver period continued, we would have served 15,243 individuals in nursing homes. We accomplished this by diverting from nursing home care approximately 4,200 individuals and by relocating approximately 3,110 individuals from nursing facility placements to community settings. Although it was not the intent of the waivers to save state and federal money, we were able to accomplish substantial savings (about $7.5 million) in federal dollars (and 12 million total dollars) during those three years.

We were, therefore, somewhat surprised, when in the Spring of 1984, HCFA's Region X office encouraged us to submit our application for renewal of our waiver as early as possible. We were told that many questions were being raised about the effectiveness of the waivers nationally by HCFA's Central Office, and by the Office of Management and Budget. Taking heed of this advice, we developed an application for renewal of our waiver and submitted it to the Health Care Financing Administration on June 1, 1984, nearly seven months before our first waiver was due to expire. Our renewal application made only minor changes in some of the services which were described in the initial approved waiver. Therefore, we expected a pro-forma approval of our renewal request as, we beleive, is contemplated in the law.

We had also heard a rumor that the Health Care Financing Administration was developing a draft set of regulations pertaining to waivers which would make application perceivers for waivers much more difficult. On June 4, 1984, Senator Packwood's office wrote Carolyne Davis, Administrator of Health Care Financing Administration, asking for a copy of any such draft regulations. Those draft regulations were, as far as we know, never supplied to him although we now know that they were in the process of being developed.

Toward the end of July of 1984, we began to hear some rather disquieting rumors from the state of Georgia about problems that state was facing in obtaining a renewal of its initial waiver. Although the state of Georgia had submitted its original Home and Community Based Care Waiver request subsequent to the time Oregon had done so, the Georgia request had been approved retroactively. Therefore, Georgia was about two months ahead of Oregon in going through the process required to obtain a renewal of its waiver. We heard, for instance, that the state of

Georgia had been asked to supply data regarding the cost-effectiveness of its waivers, which took into consideration such non-Medicaid programs as Food Stamps and Supplemental Security Income. Georgia had been supplied an interrogatory several pages long by the Health Care Financing Administration requesting mountains of documentation. The Health Care Financing Administration, we found, took the position that even though Georgia had requested a renewal of an existing waiver, HCFA was going to consider it a new waiver because of some changes in the population served and the services being offered by that state.

Because of the concerns we knew which were being raised about Georgia's renewal package, our staff put together a presentation package for the Health Care Financing Administration dealing with questions we felt HCFA might raise regarding our own pending renewal application. Our data quite clearly showed HCFA that Oregon's waiver had been cost-effective even after taking into account expenditures for the food stamp program and SSI programs. On August 17, 1984, I personally traveled to Baltimore along with my deputy, Jim Wilson, and Jan Curry, the Deputy Administrator of our Mental Health Division. Our purpose was to meet with HCFA officials in order to present our data to them and other officials of the Department of Health and Human Services. We met with Dr. Henry Dismaris and with Robert Wren of HCFA. Although we were courteously received by them, when we asked them what kinds of questions HCFA would be raising with respect to Oregon's waiver, we were met by silence. However, on the day we returned from Baltimore (August 20, 1984), we found a ten-page list of questions signed by an official of the HCFA Regional Office in Seattle. Those questions asked for large numbers of details regarding our existing waiver, as well as numerous assurances regarding our planned 85-87 waiver. Their letter informed us that our waiver would be treated by HCFA as a new waiver, not renewal of an existing waiver, because of the minor changes in services we had requested in the renewal package.

The significance of treating a waiver as a new waiver instead of a renewal of a waiver is very important, Mr. Chairman. If a waiver is treated as a renewal of an existing waiver, the Secretary has 90 days to consider the renewal and either accept or reject it. However, if the waiver can be treated as a new waiver, the Secretary is allowed to ask whatever questions he or she wishes, within an initial 90-day period. The state then has to supply answers satisfactory to the Secretary regarding whatever questions the Secretary might raise. The Secretary, after receiving answers to those questions, has an additional 90 days to make a decision. For Oregon, this meant that HCFA was able to subject our staff to an additional 90 days of questioning and requests for documentation than we had expected. To find the answers to those questions and the requested documentation required hundreds of man hours. Most other business in our office came to a standstill for several months while nearly all of our available staff worked, sometimes until 2:00 or 3:00 o'clock in the morning, dealing with various requests from HCFA officials, many of which came over the telephone, each time with the implication that if the information were not supplied, our waiver would not be renewed.

On August 29, 1984, I, along with my deputy, and Leo Hegstrom, the Director of Oregon's Department of Human Resources, met in Salem, Oregon, with David Kleinburg of the Office of Management and Budget. He was in Oregon at the time on other business. Mr. Kleinburg only managed to confirm our worst fears about the Office of Management and Budget's stance regarding Home and Community Based Waivers. He told us, among other things, that the Office of Management and Budget did not want to see waivers renewed which served populations in the community larger than the population the states had been serving prior to the time that Section 2176 was passed. He left it quite clear that he and Mr. Stockman were not happy with the most states' performance on Home and Community Based Care Waivers.

On September 18, 1984, we placed in the mail our answers to HCFA's ten pages of interrogatory. We also agreed to separate that portion of our waiver dealing with the mentally retarded population out from the portion dealing with the rest of the populations (the elderly and disabled). By doing so, we felt that we would enhance chances of approval of the waiver dealing with the elderly and disabled.

On October 5, 1984, after having taken another trip at the end of September to Washington, D.C., to meet with congressional staffers, we were informed by Senator Packwood's office that Oregon would be granted a 45-day extension to its initial waiver. This was actually a mixed blessing, because it gave the Health Care Financing Administration an additional 45 days to request more documentation and use up more staff time. It also meant that the several thousand individuals in Oregon receiving waivered services would have to wait 45 days more to know for certain if federal funding would be available to continue services to them. On October 10-12, I attended a conference in Santa Fe, New Mexico, of state agency personnel dealing with waivers from around the United States. At that time, I finally obtained a copy of the draft regulations pertaining to the waivers which the Health Care Financing Administration had been working on for several months. Those draft regulations differed very little from the ones that ended up being published on March 13, 1985. After reviewing those regulations, it became clear that Oregon was being requested to supply documentation which would later be required in the final March 13, 1985 regulations. In other words, Oregon was being required to comply with regulations which had not yet been published.

On October 17, 1984, I, Mr. Wilson and Mr. Leo Hegstrom, the Director of Oregon's Department of Human Resources, went to Washington, DC, and met personally with Carolyne Davis, the Administrator of the Health Care Financing Administration, and some of her staff. Our purpose was to determine what further steps needed to be taken by Oregon to obtain approval of its "new" waiver. At this time, we were presented with a new list of conditions that Oregon would have to meet, one of which was to place a limit on the number of individuals who would be served along with additional request for documentation. Also, we were asked to totally rewrite our waiver application in spite of the fact that we had sent several pounds of documentation supporting each of the sections in our June 1 waiver application document. Because we had so much time invested in the waiver and because it is so essential to achieving a balance in our long-term care system, we acquiesced.

On October 29, 1984, Mr. Hegstrom, Mr. Wilson, and I met with Joseph Anderson, the Region X director of the Health Care Financing Administration in Portland. At that time, we were again told flatly that the state of Oregon would be expected to adhere to a limit on the number of persons served through the 85-87 waiver.

On November 14, 1984, my deputy, Mr. Wilson and other Senior Services Division staff traveled to Seattle, Washington and reached what they thought was an agreement with Region X HCFA staff on the numbers of individuals HCFA would allow to be served under the waiver as well as the growth rates in the community and nursing home populations which would be allowable. From that date, until the waiver was due to expire on December 21, 1984, our staff were in almost continuous contact with the Region by telephone, making several revisions to the wording on various pages of the waiver document. For instance, on December 19, 1984, we received a call from the Region X HCFA office and were informed that HCFA wanted additional assurances, in writing, that no financial participation would be claimed by the state on community based services for situations where a spouse was the provider of the service. We were also asked to withdraw the answers to any questions which we had provided in response to the Region's ten-page letter of August 20, 1984 and instead, to incorporate those answers in our waiver document. This meant we once again had to rework most of the waiver document. By this time, some pages in the waiver had been rewritten three to four times.

Then, during the first week of January, HCFA requested that I again travel to Baltimore and reach another "final" agreement on the numbers of persons who would be served in the 85-87 waiver. At that time, Mr. Robert Wren literally dictated the numbers which would be acceptable to HCFA on a napkin over lunch at a Baltimore restaurant. Those numbers were lower than the ones which had been agreed upon with the Region in November.

Finally, after one additional phone call from the Region relaying some questions which we were told came from the Office of Management and Budget (those questions demonstrated a complete lack of understanding of the waiver and we refused to answer them and complained to Senator Packwood's office) we received a letter on February 6, granting us a waiver retroactively from December 22, 1984 to December 21, 1987.

At this point, you are probably asking yourself why the state made so many concessions. The main reason for this is that, at least in the state of Oregon, the waiver is no longer in the experimental stage. Our waiver was in operation statewide serving over 5,000 individuals. If funding for the waiver had been lost, our nursing homes would have immediately filled and there would have been considerable demand to build more nursing home beds. We simply could not afford to have that sort of situation occur either fiscally or in terms of the human suffering. Being over that kind of barrel, we found ourselves making concessions inch-by-inch as each new demand was made.

The period of June 1, 1984 through January 31, 1985 was one of almost continuous harassment by the Health Care Financing Administration and the Office of Management and Budget. The waiver document which was finally approved was considerably different from the one we had submitted.

II. Concerns With March 13, 1985 Regulations

It is Oregon's position that complying with HCFA's regulations of March 13, 1985 will put the states back in a position where it is fiscally more attractive to place individuals in nursing homes than to place them in community based care. The regulations demonstrate a fundamental lack of understanding of how long-term care systems operate in a state.

The first major problem in the regulations is that they isolate and limit the population which will be served under the waivers and ignore their relationship to Medicaid eligible individuals in nursing homes who are being served at costs of two to three times the cost of like individuals in community settings. The wording in the new regulations found in 42 CFR 441.302 says, "The agency's actual total expenditures for home and community based services under the waiver and its claim for FFP in expenditures for the services will not exceed the approved estimates for those services as expressed as the product of C X D in the supporting documentation required...." That regulation refers to a formula in which C equals the estimated number of individuals who would require home and community based services under the waiver and D equals the estimated annual Medicaid expenditures per individual. The regulations go on to say if the product of C X D is exceeded, the Health Care Financing Administrator can terminate the waiver. This, we presume, could occur even if the state's expenditures were lower than what they would have been had the individuals served under the waiver been served in nursing homes.

The regulations make it clear that states cannot exceed their estimates. This puts the states in the position of trying to guess, three years in advance, how many people will actually be served under the waivers and then rigidly adhering to whatever estimates it has made whether adherence to those estimates make sense or not.

When Congress passed Section 1915(c) of the Social Security Act, we believe its concern was that aggregate expenditures under the waiver did not exceed those which would have occurred in the absence of the waiver. In our extensive conversations with congressional staff who developed Section 1915(c), we found no evidence that the intent of the waivers was simply to save money. The intent was that the waiver would not cause aggregate expenditures under the state's medical program to grow any more than they would have, had the waivers not been in place.

Another basic problem with the March 13 regulations, one which demonstrates HCFA's lack of understanding of how a long-term care system operates, is found in the documentation requirements of 42 CFR 441.303(f). That regulations says, "States must. . .show the number of beds in Medicaid SNF's and ICF's. . .and evidence of the need for additional bed capacity in the absence of the waiver. States which propose a waiver population which would exceed the capacity of presently certified beds must produce viable certificates of need and other documentation that beds would actually be built and certified absent the waiver."

This regulation is a virtual Catch-22 because it limits the waiver population to the number of available certified beds in nursing homes. Estimates exceeding certified bed capacity will be found "unreasonable" by HCFA. We have found, in our several years of operating a long-term care system, that we must serve 2.6 individuals in the community in order to reduce the nursing facility beds paid for by Medicaid by one. This is simply a function of how the long-term care system operates. We cannot prevent qualified persons from being served in nursing facilities and since an empty nursing home bed creates a strong attraction for additional private and public clients, we must divert or relocate approximately five individuals to serve two fewer individuals with like impairment levels in a nursing home bed. This expansion can be accomplished using fewer federal dollars than would have been expended on nursing home beds for those individuals whose impairment levels would allow them to be placed in nursing homes because the cost of the community bed is about one-third the cost of the nursing home bed.

The regulations' requirements for estimating how many individuals the state will be able to serve in a community setting also make little sense. The preamble to the regulations say, "In developing the estimates of utilization...the state must continue to use actual data on nursing home cost and utilization based on cost and utilization of community based services for the most recent year before the waiver takes place." Again, the regulations assume a one-to-one ratio of persons in the community to persons in nursing home beds. They seem to be premised on the theory that a nursing home bed must be kept available for each person on waivers in the community.

Any state which has been successful in controlling the utilization of long-term care institutionalization will suffer because of these regulations. In Oregon, between October 1980 and October 1983, nursing home beds increased by 2.1% (from 14,938 to 15,256). This expansion did not keep up with the population increase during the same period of time for the population at risk (age 75 and above), which over the same period of time was 10.7%. Oregon nursing home beds per thousand individuals age 75 and over dropped from 124 in October 1980 to 114 in October 1983, reflecting a reduction in occupancy rates from 92% to 90%. Oregon has achieved success in controlling the utilization of nursing facilities, but has done so by expanding community resources. We do not have nursing facility beds available for all people who are in community settings. To have them available would be expensive and unneeded. HCFA's methods of assessing our waivers seem to transmit a message to the states that if they want to expand the number of persons in community based waivers, they should go out and see that more nursing home beds are built. They thus penalize the states which have effectively reduced nursing home populations.

Another significant problem with the waiver regulations is that the waivers may be terminated if the states' total expenditures for any one of the three years of the waiver exceed the estimates which the state made for each of the three years of the waiver. This puts some states in a peculiar situation. It is possible, especially when one considers the regulations' requirement that states separate out waivers dealing with the aged, blind, and disabled from those dealing with the mentally retarded, that a state might have to spend more during one year of the waiver to develop community resources than it would have cost to keep the population institutionalized, yet could achieve significant savings in subsequent years of the waiver. In spite of that, a state must keep its expenditures below its estimates in each of the three years of the waiver or face termination of the waiver.

A matter of great concern to our Mental Health Division, which just recently received approval of a very scaled down waiver for the mentally retarded, is that states are required to provide assurances that payments will not be made for educational or vocational services, although HCFA has developed no definitions of such services. That, in and of itself, is a problem, but HCFA has exacerbated that situation with respect to Oregon by refusing to allow the state to define these services. Nor will HCFA allow Oregon to use other federal agency definitions, such as those of the Department of Labor.

In the preamble to its March 13 regulations, HCFA stated: "We do not believe that pre-vocational and vocational training and educational activities are normally furnished as a means of avoiding institutionalization," even though they offer no data in support of this belief, while data exists from state and local sources (see attachment to a statement provided the committee by Marilee Trapp from the United Cerebral Palsy Association of Pittsburgh), indicating that such services are effective in preventing institutionalization.

We have a number of problems with several documentation requirements in the regulations which we consider unduly burdensome. For instance, in 42 CFR 441.303(f)(4), the states are required to provide specific identification of the number of clients who will be relocated or in other words deinstitutionalized as compared to those who will be diverted or, in HCFA's parlance, "deflected" from nursing homes. In other words, those who could qualify for nursing home care, but do not end up in a nursing home because they have been placed in a community setting. For those clients who are diverted or deflected, the statements specify exactly where those clients will be coming from and how many will come from each situation or location. This regulation is almost impossible to comply with and it puts the states in a position of making estimates about events which will occur three years or more in advance of when those estimates are made and it will be extremely difficult to "guess" very accurately that far in advance.

We object to the very strict interpretation in the regulations of what constitutes a "new" waiver. The regulations legitimize those actions which the Secretary had taken with respect to our state and several others prior to their March 13 publication. They gave the Secretary the authority to redesignate existing waivers as "new" even when minor changes had been made from the state's previous waiver. The net effect of this is that the Secretary can then impose a myriad of extraneous requirements on the states every three years.

The above actions will be especially onerous when combined with the provision in 42 CFR 441.304(g) which says that after September 9, 1985, the Secretary will not allow funding for a new waiver until (as is stated in the preamble to the regulations) ". . . all issues are resolved and we are sure that the waiver program will be operated in accordance with applicable regulations." This means that the Secretary has placed herself in a position "officially" to convert even functioning and currently approved waivers into "new" waivers, and then to hold back funding for such "new" waivers until some level of satisfaction (the level of which is not made known to the states) is reached in HCFA and OMB. In Oregon, this will mean that in three years, thousands of Oregonians receiving services through the waivers will again live in fear that the funding for their services may evaporate while HCFA is becoming "satisfied." The difference this time will be that the March 13th regulations will not allow retroactive approval of waivers. Our state will be faced with having to shut its program down or drastically reduce it and would thereby eliminate years of gains it has made in developing a system of providers of in-home services.

III. Recommended Future Actions

I hope, Mr. Chariman, that my testimony to this point has shown that the Home and Community Based Waiver program, especially as currently administered by HCFA and OMB, has only a slim chance, if any, of providing any kind of long-term solution to what is one of the largest social issues facing this nation today. We cannot, especially when faced with a situation where the elderly are becoming a larger segment of our population, continue to scale back the resources available to state and local governments which will allow them to care for persons at risk of institutionalization. Neither can we continue using the regulatory process to encourage the institutionalization of such invididuals by forcing a medical model of care upon individuals when, more often than not, their problems are functional in nature.

I believe that the bills sponsored by Senator Bradley in the Senate and Congressman Wyden in the House represent a step forward in that they would allow Medicaid funding as an optional service for home and community based care.

Oregon recently conducted a survey of state Medicaid and Agency on Aging directors. I have attached a preliminary report of the findings of that survey. As you can see, over 93% of those who administer home and community based services in the country are dissatisfied with the present situation. It should also be noted that a majority of them feel that the Waivers should be made an optional program under Title XIX, as the Bradley/Wyden bill would allow.

However, Mr. Chairman, it should be pointed out that an option which ranks second among those surveyed is to create a completely separate title to the Social Security Act. My personal preference is that the latter should be Congress's goal for passage within the next four to five years. I also believe that adequate funds are already available for the population presently eligible for Medicaid to meet their needs simply by lifting the regulations presently devoted to nursing home, home, health, personal care and funding for the present waiver program out of Title XIX and devoting it to the new title. I believe Oregon and other states have adequately demonstrated that when a state aggressively manages its long-term care systems, the needs of those Medicaid eligibles who are at risk of nursing home care can be met within existing resources. This cannot be accomplished by strapping the states with a limit on the number of people who will be served as HCFA mandates it in its March 13th regulations. In fact, it is very probable that a population larger than that which would fill available nursing home beds will have to be served, but they can be served when the state truly is given the flexibility to meet their needs in a non-medical and non-institutional setting.

One thing is certain, Mr. Chairman. We cannot continue the present situation as administered by HCFA. Oregon is in no position to again expend the kind of resources it had to expend to obtain its present waiver. Nor do I, personally, want to again see thousands of Oregonians receiving waivered services to again live in fear that those services might be terminated because some petty bureaucrat in HCFA is not satisfied with the documentation we have sent. I urge you to take action quickly to make the waiver a permanent part of the Medicaid program as an optional service, but in the long run, a more definitive and long-range solution the problem needs to be taken by addressing it separately from the Medicaid program.

NAMES
NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

STATEMENT

of the

NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

before the

HOUSE SELECT COMMITTEE ON AGING

July 9, 1985

618 SOUTH ALFRED STREET ALEXANDRIA, VIRGINIA 22314 (703) 836-6263

SUMMARY

NAMES supports the Administration's budget proposal to freeze and index durable medical equipment (DME) rental charges as part of the overall effort to reduce the budget deficit.

However, the effect of the budget freeze proposal must be considered in light of three major policy and reimbursement initiatives for Medicare DME recently introduced and implemented by HCFA. These initiatives include oxygen coverage guidelines, oxygen reimbursement guidelines, and rent/purchase payment procedures. Other proposed Medicare initiatives are also expected to have a negative effect.

The effect on rate of assignment, quality of products and service on the equipment resulting from recent policy changes and the ensuing effects on Medicare beneficiaries must be assessed. We project a lower rate of assignment, lower quality products and decreased service on the equipment. Access to home care may also be jeopardized as smaller suppliers go out of business.

Congress must assure before implementing the budget freeze proposal on DME purchases, that purchase charges have been established at levels that are consistent with marketplace prices. Purchase of DME before implementation of the rent/purchase payment procedure was a relatively rare occurrence in the Medicare program. Therefore, there are very few customary or prevailing purchase charges for new and used equipment. Where such purchase charges may exist, they are fraught with significant errors and are hopelessly outdated.

NAMES believes savings could be achieved by withdrawing the HCFA rent/purchase instructions for expensive DME. Additional savings would result from implementing the NAMES alternative payment proposal. Savings from both actions -- withdrawing rent/purchase for expensive equipment; implementing NAMES alternative -- are documented in the February 13, 1985 draft GAO report on DME.

STATEMENT OF NAMES
BEFORE THE
SELECT COMMITTEE ON AGING

Thank you, Mr. Chairman, for allowing the National Association of Medical Equipment Suppliers (NAMES) to present its views regarding the effects of the Administration's budget proposals on the Medicare program.

NAMES, with a membership of over 1,400, is the largest trade association representing home care medical equipment suppliers throughout the country. Our members serve over 2 million patients who are able to avoid institutionalization because of the availability of medical equipment ranging from walkers and wheelchairs to oxygen-related items to high tech nutritional therapy. Home care equipment suppliers provide not only the equipment but also the services that are essential to assure proper functioning and use of the equipment in the home. Most NAMES members serve Medicare beneficiaries.

I. NAMES SUPPORTS A DME FREEZE

Mr. Chairman, NAMES supports the Administration's budget proposal to freeze the customary and prevailing rental charges for durable medical equipment (DME) beginning in fiscal year 1986. We have not seen the actual proposed budget legislation. Therefore, we are not sure what is proposed to be frozen. Mr. Chairman, NAMES supports a freeze that applies to the lower of the supplier's data-generated customary charge or the 75th percentile of the data-generated customary charges for all suppliers in a given locality. This is referred to as the reasonable charge methodology and is set out in Section 1842 B of the Medicare statute.

The budget freeze proposal has been construed as a limit on increase, however, a true freeze would assure that prices cannot be lowered or raised.

Oxygen Reimbursement. HCFA implemented on April 1, 1985, a nationwide system of limiting Medicare payment for oxygen under the DME benefit. The HCFA initiative (PATROL Transmittal No. 18-3) directs carriers to pay for all oxygen at a standard per cubic foot rate. This PATROL initiative was not subject to notice and comment through Federal Register publication or any other outside input. HCFA expects this initiative to achieve savings for Medicare. However, it will also cause beneficiary hardship particularly because of the elimination of a fair price for portable gaseous oxygen. NAMES has requested along with doctors, manufacturers, and beneficiaries that HCFA direct carriers to establish a separate pricing method for portable oxygen cylinders.

Unlike portable liquid oxygen systems, portable gaseous oxygen cylinders cannot be transfilled in the home due to extraordinary fire and explosion hazards associated with high pressure cylinders. There are extensive federal regulations and industry safety procedures which must be met to transfill gaseous cylinders. It is beyond the technical and financial ability of most Medicare beneficiaries to meet these requirements and is certainly an error for HCFA, as a matter of policy, to establish reimbursement rates on the assumption that a beneficiary can transfill in his home.

While NAMES supports efforts to achieve a reasonable balance in oxygen payment, reimbursement policy should not be used to restrain utilization — coverage guidelines serve that purpose. The proposed reimbursement for portable gaseous oxygen which is substantially lower than market prices is a barrier to beneficiaries' access to necessary and appropriate portable gaseous oxygen, as demonstrated in HCFA Region IV.

Oxygen Coverage -- The April 5, 1985, publication by HCFA of a final notice on oxygen coverage guidelines may result in reduced utilization of oxygen and, therefore, may result in additional Medicare savings. The oxygen coverage guidelines establish uniform, nationwide criteria which a beneficiary must meet to receive Medicare oxygen benefits. NAMES supports such an effort to bring predictability and consistency to oxygen coverage determinations.

Rent/Purchase -- HCFA implemented on February 1, 1985, the DME rent/purchase guidelines. These carrier guidelines drastically revise the method for determining payment for DME by requiring purchase rather than rental. A closer examination of the data from the GAO's draft report reveals quite different savings outcomes for expensive and inexpensive DME. Therefore, at the outset we must distinguish between the rent/purchase policy change for inexpensive equipment (costing less than $120.00) and expensive equipment.

HCFA's action on implementing rent/purchase payment for inexpensive DME seems appropriate because it is likely to: 1) reduce Medicare outlays, 2) not increase claims administration expenses, 3) not disrupt the Medicare beneficiary benefit for DME and, 4) resolve abuses of long term rentals of inexpensive equipment. NAMES has supported such action since 1982.

By contrast HCFA's action which increases purchase of expensive equipment (costing more than $120) is an egregious error because, according to the HCFA-Williams College and GAO reports it is likely to: 1) not reduce Medicare outlays, 2) increase claims administration expenses and 3) disrupt beneficiary service by eliminating routine maintainence and the DME benefit. Therefore, Congressional attention at this time must focus on HCFA's action on Medicare payment for purchase of expensive DME.

NAMES long-time position has been that reimbursement for items costing $120 or less should be limited to the purchase price. In addition, NAMES developed an alternative reimbursement formula for expensive equipment designed to eliminate abuses while recognizing the fact that the DME industry is labor intensive, service and maintenance oriented. The acquisition cost of DME is only a small percentage of the total cost of doing business. The NAMES payment alternative has been communicated to both the Congress and HCFA many times over the last two years.

Implementation of the rent/purchase guidelines for expensive DME has not gone well. Despite HCFA's claims that Medicare carriers and the DME industry have had two or three years to prepare for implementation -- the plain fact is that carriers, beneficiaries and suppliers were unprepared. Today, more than five months after implementation, every DME supplier is uncertain about how his Medicare claims will be processed, what price will be used and when he will be paid.

It is not just a few inefficient carriers who are having trouble — all carriers are having difficulty with implemention of DME rent/purchase guidelines. The problem? Unclear, inconsistent, and ambivalent instructions and directions from HCFA.

NAMES, carriers, and HCFA have been working together to develop clear and consistent implementation instructions. However, many of these implementation issues have been around since 1980 when the rent/purchase regulations were published. The prospects for clarity and consistency are dim without substantive changes in the statute. HCFA's decision to put a moratorium on oxygen equipment a month and a half after implementation illustrates the underlying problems. Paying only for the product without consideration for service needed to maintain the equipment in the home is shortsighted and leaves the beneficiary at great risk.

Despite these implementation problems and uncertainties, we feel it is important to note that beneficiaries have thus far been shielded from any uncertainty or anxiety related to their Medicare DME benefit.

This is due to the professionalism and sincere care that home care DME suppliers provide Medicare beneficiaries.

As you can see from these examples, HCFA has made in an extremely short period of time significant adjustments to the Medicare DME benefit — any one of which is as significant to DME suppliers as the shift in hospital payment to DRGs. There are additional administrative actions currently under consideration by HCFA that would have an additional impact on the DME and other Part B services. These include parenteral/enteral nutrition reimbursement, arbitrary reduction in rental charges to 1/10 of purchase charges and arbitrary reduction in oxygen concentrator charges.

It is important to note that none of these administrative initiatives as described above are subject to administrative or judicial review.

II. ESTABLISH REASONABLE AND FAIR PURCHASE CHARGES

As a result of the rent/purchase guidelines implementation, most carriers are, for the first time, developing prevailing charges for purchase of used equipment and prevailing charges for purchase of new equipment. If purchase charges are frozen, it could create severe hardships for both beneficiaries and suppliers. HCFA has recognized this problem and instructed carriers to closely examine profile purchase charges to determine if they are significantly lower than marketplace charges and make necessary upward adjustments where appropriate. NAMES, therefore, urgently requests that this committee ensure that any freeze proposal take this uncertainty into account.

Because virtually all beneficiaries choose to rent rather than purchase equipment, carriers have not had sufficient historical submitted charge data to establish purchase prevailing charges. Moreover, carriers that have established new equipment prevailing purchase charges for certain equipment have mixed submitted purchase charges for used and new equipment, as well as non-commercial (i.e., beneficiary to beneficiary) sales. Therefore, virtually all prevailing purchase charges for new equipment are significantly lower than marketplace prices.

HCFA instructed carriers to arbitrarily establish used equipment purchase prevailing charges at 75% of the new equipment purchase prevailing charge. In other words, 75% of an incorrect charge. There is no statutory basis for HCFA to arbitrarily set used prevailing charges at 75% of new prevailing charge and NAMES has vigorously opposed such action.

HCFA's recently implemented rent/purchase guidelines for Medicare DME payment provide an incentive -- waiver of coinsurance and 100% payment -- for a DME supplier submitting charges for purchase of used equipment at 75% (or less) of the new equipment reasonable charge for the same item. A subsequent HCFA instruction directed carriers to arbitrarily establish used equipment purchase prevailing charges at 75% of the new equipment purchase prevailing -- effectively eliminating the waiver incentive, not allowing "market" behavior to occur, and imposing an unfairly-low payment level.

NAMES supports the incentive provision contained in the statute at 75%. We oppose establishing the used purchase prevailing at that same level (i.e., 75% of the new purchase prevailing charge). HCFA's apparent reason for using 75% to arbitrarily set used purchase prevailing charge is to protect the beneficiary. However, the beneficiary is harmed, not protected, because his or her choices are decreased. There is no increase in Medicare DME outlays if the used purchase prevailing charge is set at a higher amount, for example 90% rather than 75% of the new equipment purchase level. In fact, there may be additional savings to the Medicare program.

Furthermore, if 90% rather than 75% is used, the beneficiary (particularly a beneficiary with supplemental insurance) would have an opportunity to purchase a higher valued item — and have the supplier take assignment. For example, a supplier may have in his or her inventory two used hospital beds. One is two months old, the other two years old. The supplier purchase price for the two month old bed is $900.00 while the two year old bed is $750.00. If the used purchase prevailing is set at 90%

(e.g., $900.00), rather than 75% (e.g., $750.00), the beneficiary has the opportunity to purchase either bed and have the supplier take assignment on either choice. The beneficiary that could not afford or does not have supplemental insurance for the coinsurance amount could select the $750.00 bed and the supplier under assignment would receive the full amount and not have to collect coinsurance from the beneficiary.

By contrast, if the used purchase prevailing is set at 75%, (e.g., $750.00) as the guidelines currently require, the beneficiary that selects that $900.00 bed would have to pay the supplier the full amount on his own because the supplier would not take assignment.

III. IMPACT OF RECENT HCFA ACTIONS ON DME BENEFIT

Mr. Chairman, the Congress and your committee should be apprised of the impact on assignment, quality and service within the Medicare DME benefit that results from the cost containment actions already taken by HCFA (i.e., oxygen reimbursement, oxygen coverage, rent/purchase payment). Summarized below is the possible impact:

Assignment -- Traditionally, Medicare beneficiaries have enjoyed a very high rate of assignment by DME suppliers. The February 13, 1985, draft General Accounting Office (GAO) report on durable medical equipment indicated that for the carriers GAO reviewed, the percent of rental claims assigned was 96.4 while the percent of purchase claims assigned was 32.8. One reason for the lower assignment rate for purchase may be that purchase prevailing charges were unacceptably low. Therefore, with the implementation of rent/purchase payment, which increases the incidence of purchase, with the carriers establishing purchase prevailing charges, and with the reduction of prevailing charges for oxygen equipment, it is likely that a decrease in the percentage of assigned claims will result.

Quality of Product -- HCFA implementation of rent/purchase for expensive equipment (equipment costing more than $120) creates a powerful incentive to provide the least expensive product possible for purchase. The DME industry strongly objects to this incentive because the lower cost equipment is usually lower quality, and the beneficiary and the Medicare program will bear this burden. Under rental, the DME supplier has an incentive to maintain quality products which remain in service for a long period of time. This contrasts with purchase where the low Medicare prevailing charges force the supplier to cut costs by providing lower cost — therefore lower quality — equipment. Lower quality equipment has a shorter product life, requires more repair and maintainence and may result in increased Medicare outlays under purchase.

This was demonstrated in a November 1984 Congressional Office of Technology Assessment case study which found that 1) the emphasis on price over performance in the reimbursement procedure has probably discouraged innovation, 2) cost comparisons are more meaningful if "total annualized costs," which includes maintenance and repair, are computed, 3) encouraging innovation may result in lower annualized costs. Neither the GAO report nor HCFA's assessment of the rent/purchase payment procedure includes this analysis.

Service, Repair and Maintenance -- Essential to the provision of DME in the beneficiary's home is the service which is necessary to keep the product, whether life-support or other DME, operating. Clearly the level of service varies according to equipment needs and beneficiary usage. Generally, the current rental charges reflect this variance while purchase charges do not.

The beneficiary, prescribing physician, and referral source recognize the medical necessity of having the equipment delivered to the patient's home. Under current hospital discharge pressure, this delivery may be required at any time (e.g., weekends, evenings) and the request for the equipment is frequently on very short notice. The supplier distribution network accommodates timely delivery. In addition, subsequently required necessary disposable supplies are delivered. Current Medicare rental charges take delivery costs into account, while most purchase charges do not.

After delivery to the patient's home, the equipment must be set-up and put in good working condition. This often requires more than simply unboxing a product and checking to see if it is working properly (calibration, etc.). For example, over 200 varieties of wheelchairs are available. The DME supplier uses his professional judgment to select the best product and make the necessary adjustments to meet the beneficiary's individual medical needs.

A thorough understanding of the equipment by the beneficiary is necessary to achieve the proper medical benefit from the equipment. Often this requires that the supplier repeat daily the instructions to the beneficiary and his family, followed-up with periodic inquiries to assure that the beneficiary is using the equipment properly. Like the first days at home with a new baby, the first days at home with new equipment are more difficult and require more intense training and attention. Ongoing training is as important as the initial training.

24 hour service - As already discussed above, the initial delivery may be required at any time. This requires 24 hour service and an emergency phone line by the DME supplier. More important, however, is the need while the patient is using the equipment, for immediate

response to service needs. The supplier has a strong incentive to provide 24 hour service to solve problems with equipment under rental. There is no incentive for 24 hour service under purchase.

Maintenance - As noted in the preceding examples any maintenance required to keep the equipment operating efficiently is covered under the Medicare rental. Most suppliers schedule periodic visits to provide routine maintenance on equipment in addition to responding to user needs for maintenance. Under purchase, Medicare would not pay for routine maintenance so the likelihood of optimum performance and useful life of the equipment is diminished.

Calibration - Certain equipment (e.g., oxygen concentrator, TENS) must be periodically calibrated to assure proper functioning of the equipment. If the equipment is rented, such calibration, like routine maintenance, would normally be performed on a regular schedule. There is no provision for Medicare payment for calibration if the equipment is purchased.

IV. ABSENCE OF REVIEW OR APPEAL

Perhaps the most serious problem for beneficiaries and DME suppliers under the Medicare Part B program is the total absence of judicial and administrative review of HCFA determinations. As a result of a series of federal court decisions in 1984, the authority for judicial review under the Medicare program is limited to the appeal procedures set out in the Medicare statutes and regulations. Under the Medicare statute there is no judicial review available to Part B beneficiaries and providers. The only review available is through an administrative procedure called a fair hearing, and is conducted by an employee of the Medicare carrier. Under Medicare regulations, a fair hearing is not available if a denial of a claim is based on a HCFA guideline, letter, memorandum, regulation, notice, or other written communication.

Thus, the oxygen reimbursement and coverage initiatives, the rent/purchase guidelines referred to above or any of the thousands of pages of HCFA determinations under the Medicare Part B program are precluded from review by anyone, be it a court of law or an administrative fair hearing. NAMES believes this situation was not intended by the Congress when the law was passed in 1965, but results from a series of statutory amendments, regulations on the conduct of a fair hearing and court decisions. We believe this problem should be corrected by Congress.

V. CONCLUSION

The elderly have been subject to significant changes due to the recent HCFA initiatives to reduce costs for Medicare DME -- oxygen coverage, oxygen reimbursement, rent/purchase payment for inexpensive equipment. Problems with the purchase charges for new and used equipment need immediate attention. This is because, until the implementation of rent/purchase payment, there simply were no, or very few, customary or prevailing purchase charges. Congressional action on expensive DME should focus on the NAMES alternative payment proposal. The recent draft GAO report demonstrated, unlike HCFA's rent/purchase instructions for expensive equipment, that the NAMES alternative would result in savings to the Medicare program.

VI. RECOMMENDATIONS

- Consider the significant changes affecting beneficiaries receiving DME that have resulted from the policy changes recently implemented by HCFA.
- Consider the need to first establish fair and reasonable purchase charges for DME before freezing those charges.
- Consider the savings that would be achieved by withdrawing the HCFA rent/purchase payment instructions for expensive equipment and substituting the NAMES alternative payment proposal.
- Consider the need for Congress to provide review and appeal for Medicare Part B beneficiaries and providers.

SOCIETY OF PROFESSIONAL BENEFIT ADMINISTRATORS
2033 M Street, NW • Suite 605 • Washington, D.C. 20036 • (202) 223-6413

Testimony of the Society of Professional Benefit Administrators (SPBA)
by Executive Director Frederick D. Hunt, Jr.

U.S. House of Representatives
Select Committee on Aging

Hearing on Health Care Cost Containment:
Are America's Aged Protected?
July 9th, 1985

Vast numbers of America's retirees and their dependents will probably soon lose their private health insurance coverage. The culprits responsible for this loss are the Congress of the United States and the Administration.

Prior to 1984, an ever-increasing number of retired workers and their dependents were receiving free or subsidized health insurance coverage. Sometimes it was total coverage similar to that offered active workers, and sometimes the retiree coverage was coordinated with Medicare. In any case, older Americans could expect a much more secure future...with the knowledge that their medical bills for short and long-term care would be paid. Also, America's public health coverage system was saved billions of dollars because retirees had private coverage.

In 1984, Congress and the Administration passed DEFRA (the Deficit Reduction Act of 1984). For the over-40% of Americans covered by self-funded plans, DEFRA was a crippling blow to retiree health coverage. It prevents (or at the very least grossly compli-

Robert B. Swenka, President Swenka, Inc., Minneapolis, MN
John Timmer, Vice President Employee Services, Inc., Sioux Falls, S.D.
W. Ashley Harden, Secretary/Treasurer Harden & Company, Walnut Creek, CA
James M. Dawson, Immed. Past President James M. Dawson Associates, Manchester, NH
T.J. Chapman Boon-Chapman, Ltd., Austin, TX
William C. Earhart William C. Earhart Co., Portland, OR
Robert C. Gerald Group Services Administrators, Jersey City, NJ
Ted B. Hale, Jr. Self Retention Systems, Palmyra, NJ
Russell R. Naylor Comprehensive Benefits, Newtown Square, PA
Frederick D. Hunt, Jr. Executive Director

Past Presidents Council: Robert E. Kelly • Steven L. Sherman • Charles B. Jackson • Glen K. Slaughter • W. Richard Perkins

cates) employers' efforts to set aside money during an employee's working years for his retiree coverage. Not to adequately pre-fund is fiscally irresponsible. It is the kind of fiscal irresponsibility that the Congress was simultaneously reversing in the Social Security program...which now more adequately pre-funds.

Frankly, with this foolish Government edict, an employer must either be very sure of his future cash-flow, and/or terminate the coverage for retirees. The termination of coverage is not to be hard-hearted. There are already legal cases in which retirees say that an employer promised or implied retiree coverage...and employers point to DEFRA and say that without adequate pre-funding, they cannot promise or provide such coverage. This is both a blow to employee morale...and self-defeating national policy. **It merely shoves more Americans onto the already over-burdened public programs** such as Social Security, Medicare, Medicaid, VA military hospitals, and state/local welfare.

To provide a one-two punch...to be doubly sure that retirees' private health insurance coverage is terminated, Congress and the Administration have increasingly adopted "cost-shifting"...government-promised services to now be paid by private employee benefit plans. Every time you hear OMB and your colleagues in the Congress talking about "saving millions & billions"...you should realize that **what they really mean is that Uncle Sam will pawn off his costs onto the private sector.** For instance, before the Congress right now is a proposal to shift the cost of "free" Veterans Administration medical care (which was promised to American vets as part of their compensation for service)...onto the private plans. VA would bill private plans for the "free" service...with the private sector not having any way to enforce cost-containment or auditing procedures.

The VA cost-shift is not alone. You have already made Medicare (promised to those over 65) secondary payor to private health insurance plans. Thus, **an employer who covers workers over 65 and/or retirees over 65 is actually penalized by Congress** for including the older person in the private plan. The **logical answer is to drop coverage for retirees and dependents,** and thus not be penalized by Congress. Of course, dropping coverage for older workers is bad national policy...but that is what you are forcing unless you begin to listen more closely when groups such as SPBA explain the cause-and-effect which you are setting off. In the case of DEFRA and the cost-shifting, we told you so over and over. You must not be overwhelmed and bow down to the staff of the Congress and Administration whose only job is to jiggle financial estimates to meet their own revenue needs. Yes, there may be some revenue gains ...but they will be more than lost by the human and financial loss of providing health coverage for older Americans from some other source.

Mr. Chairman, like you and your colleagues on this committee, our **prime concern is for the human effects of legislation...not doubtful revenue projections.** We realize that in DEFRA, the avowed purposes of the limits of pre-funding was to stamp out what even the proponents admitted was a miniscule minority of abusive plans.

We begged that the Congress "not throw out the baby with the bath water" and "not use a baseball bat instead of a fly swatter." Even those who understood our warnings told us to "calm down, it can be fixed later". Mr. Chairman, we at SPBA think that leaving America's elderly with this cancer of their coverage while the system wakes up to what it has done is cruel and foolish. We urge you to immediately begin the process to remedy this situation of limits to pre-funding and cost-shifting, and we are eager to be of whatever service we can. As you can tell from this statement, **we will not give you gobbledygook.** We will tell you like it is. As the independent administration firms for the employee benefits of 1/3 of all Americans, we have both the independence and the scope to lend useful candor to your considerations. Please feel free to call on us.

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.
429 N Street S.W. ● Suite S-605 ● Washington, D.C. 20024 ● (202) 554-0526

ADDITIONAL
TESTIMONY OF
STEPHEN G. YOVANOVICH
President and Chief Executive Officer
Visiting Nurses Association of Butler County, Inc.
Butler, Pennsylvania

on behalf of the
AMERICAN FEDERATION OF HOME HEALTH AGENCIES

House Select Committee on Aging
U.S. House of Representatives

July 9, 1985

DME Issue Statement of American Federation of Home Health Agencies

A related area in which recent federal cost containment measures have hindered the elderly's access to needed medical care is the area of durable medical equipment or DME. This area, too little understood by regulators, in my opinion, has traditionally focused equipment like hospital beds, walkers, and wheelchairs. Now, in the DRG environment, DME increasingly includes items like enteral/parenteral feeding pumps, home ventilators, and oxygen systems, that are essential to providing quality, high technology health care in the home.

Two recent changes in federal policy have made it less likely that the elderly will gain access to needed DME items: First, the July 18, 1984 requirement that home health agencies bill beneficiaries a 20 percent coinsurance for DME provided as a Medicare Part A home health service: Second, recent HCFA DME lease-purchase guidelines that severely limit reimbursement for home health agencies and DME suppliers providing DME as a Part B benefit to beneficiaries.

When a home health agency chooses to serve beneficiaries by providing DME as a Part A benefit, HCFA regulations implementing the Deficit Reduction Act of 1984 (P.L. 98-369) require that agency to bill patients for 20 percent of the DME cost. Even though the 20 percent coinsurance, if uncollected, ultimately may become a Medicare liability, home health agencies may choose not to offer DME services to avoid billing a patient directly for services. More importantly, the patient, realizing he/she faces a 20 percent coinsurance payment, may opt to go without the DME even though the equipment is medically indicated. As you are aware, this DME co-insurance is the only co-insurance that exists in the Part A home health benefit.

In the few cases where a home health agency had chosen to provide DME as a Part B benefit to patients, HCFA's new lease-purchase regulations simply do not permit adequate reimbursement. Essential and costly services like repairs, maintenance, and delivery of DME are factored into the reimbursement but are now inadequate. The result is all too predictable: home health agencies and Part B suppliers will not be able to accept Medicare assignment if their costs are not met and the elderly, facing direct billing with only partial Medicare reimbursement, will again opt to forego needed medical equipment.

In both these cases, regulatory cost-containment efforts will deny high quality, high techology DME services to Medicare beneficiaries---the very equipment that could keep them out of institutions. Fortunately, legislative remedies are available. Those provisions of P.L. 98-369 which impose a 20 percent coinsurance payment should be repealed. Home health agencies should receive 100% of reasonable costs for providing DME to patients.

In the second case, Congress should insist that HCFA establish reasonable charge screens for home health agencies and other Part B suppliers providing DME as a Part B benefit, including reimbursement for the cost of equipment repairs, maintenance and delivery. I would strongly urge the Select Committee to communicate these recommendations to the appropriate authorizing committees. Many Part B suppliers signed 12 month contracts with the Part B carriers in September of 1984, agreeing to accept Medicare assignment. The drastic changes in reimbursement for DME created by the new lease purchase regulations and confused interpretation of the new regulations have the entire DME supplier system in a state of confusion. In my opinion, many DME suppliers will not sign the renewal contract to accept assignment this year. Therefore, effective October 1, 1985, many home health agencies who have relied on a DME supplier to provide their patients with equipment and appliances will not bill Medicare on behalf of the patient and will charge the patient directly for services provided. This would create a dramatic impact on patient care, specifically high tech care and would directly or indirectly affect the referring home health agency.

In closing on the subject of elderly access to DME, I have tried to explain problems in this complex area as succinctly as possible. Nothing I can say, however, could begin to bring home the magnitude of the problem like the contacts our agency received in the past two months from beneficiaries just informed by HCFA of the new lease-purchase guidelines.

I respectfully ask that several of these examples, and the HCFA letter that prompted these patient calls, be made a part of the record. These are cases of senior citizens who felt compelled to turn in their medical equipment, including even oxygen equipment---the very equipment that is literally keeping them alive!---because of the impact of the new DME cost containment measures. These elderly speak more eloquently than I can about what happens when Medicare cost containment assumes greater importance in the minds of federal regulators than the people we are here to serve.

Pennsylvania Blue Shield **Medicare**
BOX 65 CAMP HILL PA 17011
Camp Hill, Pennsylvania 17011

05/07/85

FORM APPROVED
OMB NO. 0938-0218

MEDICARE LAW STATES THE CARRIER MUST MAKE A RENT/PURCHASE DECISION ON ALL DURABLE MEDICAL EQUIPMENT. ENCLOSED IS AN INFORMATIONAL LETTER EXPLAINING THIS NEW LAW. PLEASE READ CAREFULLY.

AFTER REVIEWING YOUR CLAIM, WE HAVE DECIDED THAT IT IS MORE REASONABLE FOR THE MEDICARE PROGRAM TO PAY FOR THE PURCHASE OF YOUR EQUIPMENT RATHER THAN RENTING IT. IF YOU DECIDE TO PURCHASE YOUR EQUIPMENT, PLEASE CONTACT YOUR SUPPLIER BECAUSE A NEW PURCHASE CLAIM MUST BE SUBMITTED.

IF YOU DECIDE TO CONTINUE RENTING YOUR EQUIPMENT, RENTAL PAYMENTS AFTER 07/01/85 WILL BE SUSTRACTED FROM THE REASONABLE PURCHASE PRICE AND WILL END WHEN THE MAXIMUM APPROVED AMOUNT IS PAID OR WHEN MEDICAL NECESSITY FOR THE EQUIPMENT ENDS, WHICH EVER COMES FIRST. WHEN THE REASONABLE PURCHASE PRICE IS REACHED, RENTAL PAYMENTS WILL STOP AND THE RENTAL PAYMENTS WILL BECOME YOUR RESPONSIBILITY.

IF YOU WOULD LIKE TO PURCHASE YOUR EQUIPMENT AND FINANCIALLY CANNOT AFFORD TO, PLEASE NOTIFY US.

PLEASE PLACE AN X IN FRONT OF ONE OF THE FOLLOWING AND RETURN THIS LETTER TO:

PENNSYLVANIA BLUE SHIELD
P.O. BOX 8806
CAMP HILL, PENNSYLVANIA 17011

HIC:
NAME: CODE: Z0520
EQUIP: AEROSOL THERAPY UNIT WITH COMPRESSOR
APPROVED AMOUNT: $139.00

_____WOULD LIKE TO PURCHASE EQUIPMENT.
_____WOULD LIKE TO CONTINUE RENTING.
_____WOULD LIKE TO PURCHASE BUT CANNOT FINANCIALLY AFFORD TO.

THANK YOU FOR YOUR PROMPT ATTENTION TO THIS MATTER.

ENCLOSURE

Exhibits

Incidents of Returned DME, Following Patient Receipt of OMB Form 0938-0218 May-June, 1985

Patient 1 - 87 Year old male; Diagnosis: Congestive Heart Failure; DME: portable oxygen unit with regulator; Equipment returned following receipt of Pennsylvania Blue Shield Letter of May 7, 1985.

Patient 2 - 79 year old male; Diagnosis: Polio, Emphysema; DME: wheelchair with removable foot rest; Equipment returned following receipt of Pennsylvania Blue Shield letter of May 7, 1985.

Patient 3 - 92 year old female; Diagnosis: Arteriosclerotic Heart Disease, Hypertension, and Tumor of the Bowel; DME: bedside commode; Equipment returned following receipt of Pennsylvania Blue Shield letter of May 7, 1985.

Pennsylvania Blue Shield
Camp Hill, Pennsylvania 17011

Medicare
BOX 65, CAMP HILL, PA 17011

07/22/85

6941A

VISITING HOME CARE SERV
122 BUTLER MALL
BUTLER PA 16001

WE HAVE RECEIVED YOUR CLAIM FOR REIMBURSEMENT FOR THE PURCHASE OF HOSPITAL BED, VARIABLE HEIGHT, (HI-LO), WITH MATTRESS IN THE AMOUNT OF $645.50. MEDICARE WILL BE ABLE TO ALLOW UP TO $484.10 FOR THE MEDICAL EQUIPMENT WHICH WAS PURCHASED.

ACCORDING TO THE MEDICARE LAW, REIMBURSEMENT FOR THE PURCHASE OF DURABLE MEDICAL EQUIPMENT IS TO BE MADE IN MONTHLY INSTALLMENTS BASED ON THE REASONABLE MONTHLY RENTAL CHARGE. THESE MONTHLY INSTALLMENTS WILL CONTINUE UNTIL THE ALLOWED PURCHASE PRICE HAS BEEN MET OR THE MEDICAL MONTHS OF NECESSITY SPECIFIED IN THE PRESCRIPTION HAVE BEEN MET, WHICHEVER COMES FIRST. THESE INSTALLMENTS ARE PAYABLE AT 80% OF THE AMOUNTS STATED BELOW AFTER ANY REMAINING DEDUCTIBLE AMOUNTS ARE MET.

3 MONTHLY INSTALLMENTS AT $ 75.00 ALLOWED CHARGE
0 MONTHLY INSTALLMENTS AT $ .00 ALLOWED CHARGE
TOTAL ALLOWED CHARGE AT $ 225.00

THE PURCHASE OF DURABLE MEDICAL EQUIPMENT IS COVERED BY MEDICARE ONLY WHEN THE EQUIPMENT IS USED IN THE PATIENT'S HOME. THEREFORE, IN THE EVENT OF DEATH OR ENTRANCE INTO A HOSPITAL OR EXTENDED CARE FACILITY PARTICIPATING IN THE MEDICARE PROGRAM, THIS EQUIPMENT WILL NO LONGER BE A COVERED EXPENSE AND THE MONTHLY INSTALLMENTS WILL BE DISCONTINUED.

SINCERELY,

MEDICARE CLAIMS DEPARTMENT

A COPY OF THIS LETTER HAS BEEN SENT TO:

HELEN ______

BUTLER PA 16001

RECEIVED
JUL 29 1985
VHCS

Pennsylvania Blue Shield
Camp Hill, Pennsylvania 17011

Medicare
BOX 89, CAMP HILL, PA 17011

07/22/85

6941A

VISITING HOME CARE SERV
122 BUTLER MALL
BUTLER PA 16001

WE HAVE RECEIVED YOUR CLAIM FOR REIMBURSEMENT FOR THE PURCHASE OF TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR IN THE AMOUNT OF $325.00. MEDICARE WILL BE ABLE TO ALLOW UP TO $112.50 FOR THE MEDICAL EQUIPMENT WHICH WAS PURCHASED.

ACCORDING TO THE MEDICARE LAW, REIMBURSEMENT FOR THE PURCHASE OF DURABLE MEDICAL EQUIPMENT IS TO BE MADE IN MONTHLY INSTALLMENTS BASED ON THE REASONABLE MONTHLY RENTAL CHARGE. THESE MONTHLY INSTALLMENTS WILL CONTINUE UNTIL THE ALLOWED PURCHASE PRICE HAS BEEN MET OR THE MEDICAL MONTHS OF NECESSITY SPECIFIED IN THE PRESCRIPTION HAVE BEEN MET, WHICHEVER COMES FIRST. THESE INSTALLMENTS ARE PAYABLE AT 80% OF THE AMOUNTS STATED BELOW AFTER ANY REMAINING DEDUCTIBLE AMOUNTS ARE MET.

3 MONTHLY INSTALLMENTS AT $	28.00	ALLOWED CHARGE
0 MONTHLY INSTALLMENTS AT $	.00	ALLOWED CHARGE
TOTAL ALLOWED CHARGE AT $	84.00	

THE PURCHASE OF DURABLE MEDICAL EQUIPMENT IS COVERED BY MEDICARE ONLY WHEN THE EQUIPMENT IS USED IN THE PATIENT'S HOME. THEREFORE, IN THE EVENT OF DEATH OR ENTRANCE INTO A HOSPITAL OR EXTENDED CARE FACILITY PARTICIPATING IN THE MEDICARE PROGRAM, THIS EQUIPMENT WILL NO LONGER BE A COVERED EXPENSE AND THE MONTHLY INSTALLMENTS WILL BE DISCONTINUED.

SINCERELY,

MEDICARE CLAIMS DEPARTMENT

RECEIVED
JUL 29 1985
VHCS

A COPY OF THIS LETTER HAS BEEN SENT TO:

HELEN

BUTLER PA 16001

Pennsylvania Blue Shield **Medicare**
BOX 65, CAMP HILL, PA 17011
Camp Hill, Pennsylvania 17011

07/22/85

6941A

VISITING HOME CARE SERV
122 BUTLER MALL
BUTLER PA 16001

WE HAVE RECEIVED YOUR CLAIM FOR REIMBURSEMENT FOR THE PURCHASE OF BED SIDE RAILS, FULL LENGTH IN THE AMOUNT OF $175.00. MEDICARE WILL BE ABLE TO ALLOW UP TO $93.75 FOR THE MEDICAL EQUIPMENT WHICH WAS PURCHASED.

ACCORDING TO THE MEDICARE LAW, REIMBURSEMENT FOR THE PURCHASE OF DURABLE MEDICAL EQUIPMENT IS TO BE MADE IN MONTHLY INSTALLMENTS BASED ON THE REASONABLE MONTHLY RENTAL CHARGE. THESE MONTHLY INSTALLMENTS WILL CONTINUE UNTIL THE ALLOWED PURCHASE PRICE HAS BEEN MET OR THE MEDICAL MONTHS OF NECESSITY SPECIFIED IN THE PRESCRIPTION HAVE BEEN MET, WHICHEVER COMES FIRST. THESE INSTALLMENTS ARE PAYABLE AT 80% OF THE AMOUNTS STATED BELOW AFTER ANY REMAINING DEDUCTIBLE AMOUNTS ARE MET.

3 MONTHLY INSTALLMENTS AT $ 24.50 ALLOWED CHARGE
0 MONTHLY INSTALLMENTS AT $ .00 ALLOWED CHARGE
TOTAL ALLOWED CHARGE AT $ 73.50

THE PURCHASE OF DURABLE MEDICAL EQUIPMENT IS COVERED BY MEDICARE ONLY WHEN THE EQUIPMENT IS USED IN THE PATIENT'S HOME. THEREFORE, IN THE EVENT OF DEATH OR ENTRANCE INTO A HOSPITAL OR EXTENDED CARE FACILITY PARTICIPATING IN THE MEDICARE PROGRAM, THIS EQUIPMENT WILL NO LONGER BE A COVERED EXPENSE AND THE MONTHLY INSTALLMENTS WILL BE DISCONTINUED.

SINCERELY,

MEDICARE CLAIMS DEPARTMENT

A COPY OF THIS LETTER HAS BEEN SENT TO:

HELEN ________
BUTLER PA 16001

RECEIVED
JUL 29 1985
VHCS

HEALTH INSURANCE CLAIM FORM

XXXX MEDICARE ☐ CHAMPUS ☐ BLUE SHIELD ☐ OTHER

BOX 65 CAMP HILL, PA 17011 — P.O. BOX 6118 COLUMBIA S.C. 29260 — BOX 82 CAMP HILL, PA 17011

(CHECK ONLY ONE)

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

PATIENT & INSURED (SUBSCRIBER) INFORMATION

Form Approved OMB No. 02-38008

1 PATIENT'S NAME (First name, middle initial, last name): HELEN

2 PATIENT'S DATE OF BIRTH: 9 15 07

3 INSURED'S NAME (First name, middle initial, last name): SAME

4 PATIENT'S ADDRESS (Street, city, state, ZIP code): BUTLER, PA 16001

TELEPHONE NUMBER

5 PATIENT'S SEX: MALE ☐ XXX FEMALE

6 INSURED'S I.D. or MEDICARE NO. (Include any letters)

7 PATIENT'S RELATIONSHIP TO INSURED: XX

8 INSURED'S GROUP NO. (Or Group Name)

9 OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10 WAS CONDITION RELATED TO:

A PATIENT'S EMPLOYMENT: YES ☐ XX NO

B AN ACCIDENT: AUTO ☐ OTHER ☐

11 INSURED'S ADDRESS (Street, city, state, ZIP code): SAME

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing): I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below

SIGNED X Helen DATE 5/29/85

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. NOT APPLICABLE TO BLUE SHIELD

SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐

16A IF AN EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY: FROM THROUGH

DATES OF PARTIAL DISABILITY: FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED

21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES

23A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE

1 AMPUTATION, ABOVE KNEE, RIGHT LEG
2 PROSTHETIC DEVICE, RIGHT LEG
3
4

23B EPSDT YES ☐ NO ☐
FAMILY PLANNING YES ☐ NO ☐
PRIOR AUTHORIZATION NO.

24 A DATE OF SERVICE FROM TO	B* PLACE OF SERVICE	C TOS	D PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	E DIAGNOSIS CODE	F CHARGES	G DAYS OR UNITS	H LEAVE BLANK
5/23/85	H		E0255	PURCHASE - USED EQUIPMENT VARIABLE HEIGHT HOSPITAL BED/MATTRESS	1,2	645 50		80.00
			E0310	PURCHASE-USED EQUIPMENT BED SIDE RAILS, FULL LENGTH	1,2	175.00		25.00
			E0940	TRAPEZE BAR SET, FREE STANDING WITH BAR - PURCHASE- USED	1,2	325.00		45.00

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Norma J. Yovanovich DATE 6/04/85

26 ACCEPT ASSIGNMENT (FOR GOVERNMENT CLAIMS ONLY) (SEE BACK): YES XXXX NO

27 TOTAL CHARGE: 1,145 50

28 AMOUNT PAID: 0 00

29 BALANCE DUE: 1,145.50

30 YOUR SOCIAL SECURITY NO.

31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & I.D. NO.

50 087 **VI200536**

VISITING HOME CARE SERV INC
310 NEW CASTLE RD 122
BUTLER PA 16001

32 YOUR PATIENT'S ACCOUNT NO.

33 YOUR EMPLOYER I.D. NO.: 25-1411844

34 YOUR TELEPHONE NO.: (412)-285-1888

*PLACE OF SERVICE CODES ON THE BACK

REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS

Form HCFA - 1500 A
Form CHAMPUS - 501 12/81

Pennsylvania Blue Shield **Medicare**
BOX 89 CAMP HILL PA 17011
Camp Hill, Pennsylvania 17011

05/07/85

FORM APPROVED
OMB NO. 0938-0218

HELEN ______________
____
BUTLER, PA 16001

MEDICARE LAW STATES THE CARRIER MUST MAKE A RENT/PURCHASE DECISION ON ALL DURABLE MEDICAL EQUIPMENT. ENCLOSED IS AN INFORMATIONAL LETTER EXPLAINING THIS NEW LAW. PLEASE READ CAREFULLY.

AFTER REVIEWING YOUR CLAIM, WE HAVE DECIDED THAT IT IS MORE REASONABLE FOR THE MEDICARE PROGRAM TO PAY FOR THE PURCHASE OF YOUR EQUIPMENT RATHER THAN RENTING IT. IF YOU DECIDE TO PURCHASE YOUR EQUIPMENT, PLEASE CONTACT YOUR SUPPLIER BECAUSE A NEW PURCHASE CLAIM MUST BE SUBMITTED.

IF YOU DECIDE TO CONTINUE RENTING YOUR EQUIPMENT, RENTAL PAYMENTS AFTER 07/01/85 WILL BE SUBTRACTED FROM THE REASONABLE PURCHASE PRICE AND WILL END WHEN THE MAXIMUM APPROVED AMOUNT IS PAID OR WHEN MEDICAL NECESSITY FOR THE EQUIPMENT ENDS, WHICH EVER COMES FIRST. WHEN THE REASONABLE PURCHASE PRICE IS REACHED, RENTAL PAYMENTS WILL STOP AND THE RENTAL PAYMENTS WILL BECOME YOUR RESPONSIBILITY.

IF YOU WOULD LIKE TO PURCHASE YOUR EQUIPMENT AND FINANCIALLY CANNOT AFFORD TO, PLEASE NOTIFY US.

PLEASE PLACE AN X IN FRONT OF ONE OF THE FOLLOWING AND RETURN THIS LETTER TO:

PENNSYLVANIA BLUE SHIELD
P.O. BOX 8806
CAMP HILL, PENNSYLVANIA 17011

HIC: ______6941A
NAME: HELEN ______________ CODE: E0255
EQUIP: HOSPITAL BED, VARIABLE HEIGHT, (HI-LO), WITH MATTRESS
APPROVED AMOUNT: $645.50 ✓
____WOULD LIKE TO PURCHASE EQUIPMENT.
____WOULD LIKE TO CONTINUE RENTING.
____WOULD LIKE TO PURCHASE BUT CANNOT FINANCIALLY AFFORD TO.

HIC: ______6941A
NAME: HELEN ______________ CODE: E0310
EQUIP: BED SIDE RAILS, FULL LENGTH
APPROVED AMOUNT: $125.00 ✓
____WOULD LIKE TO PURCHASE EQUIPMENT.
____WOULD LIKE TO CONTINUE RENTING.
____WOULD LIKE TO PURCHASE BUT CANNOT FINANCIALLY AFFORD TO.

Pennsylvania Blue Shield **Medicare**
BOX 65, CAMP HILL, PA 17011
Camp Hill, Pennsylvania 17011

HIC: ______6941A
NAME: HELEN ______________ CODE: E0940
EQUIP: TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR
APPROVED AMOUNT: $150.00
_____WOULD LIKE TO PURCHASE EQUIPMENT.
_____WOULD LIKE TO CONTINUE RENTING.
_____WOULD LIKE TO PURCHASE BUT CANNOT FINANCIALLY AFFORD TO.

THANK YOU FOR YOUR PROMPT ATTENTION TO THIS MATTER.

ENCLOSURE

HOW MEDICARE HELPS PAY FOR DURABLE MEDICAL EQUIPMENT

If you are going to need a wheelchair, hospital bed or other durable medical equipment (DME) prescribed by your doctor, you may already know that Medicare medical insurance (Part B) can help pay for it. What you may not know is that there has been a change in the Medicare rules on renting or buying such equipment.

Should I rent or buy?

The decision to rent or buy DME is still yours. However, if you decide to rent, you should know that Medicare generally will no longer pay for rentals indefinitely. To help you make your decision, you should ask your doctor how long you will need the equipment and ask your supplier about his rental rates and sales prices.

Items costing $120 or less to buy

If an item costs $120 or less and you will need it for only a short time (for example, 1 or 2 months), you are probably better off renting it. But if you need the equipment for more than a few months, you should consider buying it. This is because Medicare will not pay more in rental charges than would be paid if the equipment had been bought. For example:

> Mrs. Baker needs a walker which has a reasonable rental allowance of $10 a month and a reasonable purchase price of $60. If the equipment is rented, Medicare will not pay any more in rental charges than if the equipment had been purchased. In this example, Medicare would make rental payments for only 6 months.

Items costing more than $120

For equipment costing more than $120, the rules are slightly different. If equipment is rented when it would have been less costly to buy, Medicare will also limit reimbursement to the amount that would be paid for buying the equipment. However, the limit will not be applied beginning with the first rental month as is the case with equipment costing $120 or less. Rather, beneficiaries will receive a notice telling them when the limit will begin to be applied. For example:

> In July 1985, Mr. Greene rents a wheelchair costing $400 at $40 a month. When the rental claim is received, the carrier reviews the doctor's prescription and the expected period of time the equipment will be needed and finds that purchase will be more economical. The carrier notifies Mr. Green in August 1985 that, beginning with October, reimbursement for future rentals will be limited to the reasonable purchase price. In this example, rental payments would be allowed through July 1986. If the equipment is purchased during the period October 1985 - July 1986, any rental payments allowed in this period will be subtracted from the reasonable purchase price.

Can I buy used equipment?

You can save money if you buy used equipment. If the used equipment costs no more than 75 percent of the reasonable purchase price of new equipment, and assuming you have met the $75 deductible, Medicare will pay for the entire cost of the equipment. Thus, you will not have to pay for the 20 percent coinsurance. In order for used equipment to qualify for this saving to you, the medical equipment supplier must give you the same warranty that is offered to buyers of new equipment, and certify that the item is in good order, and that reasonable service and repair expenses will not exceed those for comparable new equipment.

Where can I get more information?

If you have any questions on renting or buying medical equipment, including other purchase plans such as installment payments, lease arrangements, or a list of participating suppliers, call or write:

In Pennsylvania and Delaware:

Pennsylvania Blue Shield
P.O. Box 65
Camp Hill, PA 17011

Toll Free (Pennsylvania): 1-800-382-1274 (Local: (717) 763-3601)
Toll Free (Delaware): 1-800-292-7865

In the District of Columbia Metropolitan Area:

Pennsylvania Blue Shield
P.O. Box 100
Camp Hill, PA 17011

Toll Free: 1-800-233-1124